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ABSTRACT

This manual represents a state-of-the-art summary of approaches in child sexual abuse interventions, emphasizing interdisciplinary cooperation between professionals in successful case management. Although prepared specifically for the use of professionals in Region II of the Massachusetts Department of Social Services and containing a service directory for the region, this handbook contains technical assistance and intervention procedural information which is generally applicable to child sexual abuse wherever it occurs. Section One, Interdisciplinary Perspectives, contains general information on what to do if a child discloses information about sexual abuse, signs of child sexual abuse, considerations for medical professionals, the court's response to child sexual abuse, child sexual abuse and the schools, and case management. Section Two, Intervention Scenarios, provides procedural information, targeted to Massachusetts and Region II, but generally applicable. It discusses the mandated reporting of child sexual abuse and provides scenarios of what happens to victims, offenders, and families. Section Three is the Region II service directory of agencies providing services to victims, non-offending parents, offenders, adult survivors of sexual abuse, and others. Section Four, Reference Material, includes legal information specific to Massachusetts and medical, prevention/education, assessment and diagnostic resources, and reference information of general interest. (NB)

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Child Sexual Abuse

An Interdisciplinary Professional Reference Manual

with
Service Directory
for Central
Massachusetts

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**The
Worcester Area
Child Sexual Abuse
Task Force**

September 1986

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The Worcester Area
Child Sexual Abuse Task Force

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United Way
of Central
Massachusetts

CHILD SEXUAL ABUSE
AN INTERDISCIPLINARY REFERENCE MANUAL
With Service Directory for
Central Massachusetts (154 pp.) See Reverse for a Description of Contents

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The Worcester Area Child Sexual Abuse Task Force announces the publication of:

CHILD SEXUAL ABUSE: An Interdisciplinary Reference Manual
With Service Directory for Central Massachusetts.

This Manual represents a state-of-the-art summary of approaches in child sexual abuse interventions. The Manual contains the thought and writing of more than 40 professionals and emphasizes important linkages in between professionals in successful case management. It illustrates why such interdisciplinary cooperation is important and how such coordination leads to better management.

The Manual suggests how to reduce the complexities of professional responses to child sexual abuse by describing how interdisciplinary cooperation works and what services are available. The dynamics of most child sexual abuse cases indicate that we are dealing with multi-troubled families. Effective decision making processes are critical given these dynamics which commonly include the "generationally repetitive" nature of sexual abuse, power relationships in the family, shame and guilt, and denial/resistance. No individual, agency or organization is capable of providing *all* services required to address the needs of all parties in child sexual abuse cases. The Manual addresses linkages which exist and others which being developed.

Worcester Area Child Sexual Abuse Task Force
c/o Massachusetts Society for the Prevention
of Cruelty to Children
286 Lincoln Street
Worcester, Massachusetts 01605

This Manual has been prepared specifically for the use of professionals in Region II of the Massachusetts Department of Social Services. It contains a service directory for this region. It also contains technical assistance and intervention procedural information which is generally applicable to child sexual abuse wherever it occurs. The Manual, therefore, should be of general use to professionals outside of Region II.

The Manual is organized modularly. That is, sections which relate to general topics are gathered in one place, principally Section One. Procedural Information, targetted to Massachusetts and Region II, but in part more generally applicable, is given in Section Two. Section Three is the Region II service directory, and Section Four includes technical information some of which is specific to Massachusetts (legal) and some of which is general (medical, prevention/education, assessment and diagnostic resources, and references).

The Manual has been designed to be integrated with your existing reference and handbook materials. Relevant portions can be filed or bound into existing materials in order to increase their usefulness and timeliness. The end of Section Four contains response forms which we urge you to examine. One requests information from agencies which are not included in the present Manual, but which provide services in the area of child sexual abuse for Region II residents and wish to be listed in a future edition. Another response form seeks information from agencies and organizations which desire training services, using this Manual as a training instrument. A third form calls for comments, suggestions for changes in future editions, and corrections and additions to current information in the Manual.

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INTRODUCTION

The prevalence of child sexual abuse is now well-known in our society. In June, 1986, two hundred and twenty-five cases of sexual abuse (271 children) were referred to appropriate District Attorney's Offices in Massachusetts. The majority of the referrals (99%) were for incidences of sexual abuse. In contrast, for the entire fiscal year 1984, 735 children were referred in sexual abuse cases, a figure which represents 91% of all abuse and neglect cases referred that year.

Also increasingly appreciated by professionals and the public at large is the complexity of the origins of child sexual abuse. This complexity suggests that an integration of legal, medical, social service, and mental health responses to child sexual abuse are most likely to result in outcomes which are most favorable to the needs of children, offenders, and the families of both. The complexity also suggests that prevention intervention and prevention education for the entire community are crucial.

This Manual is an attempt to reduce the complexities of professional responses to child sexual abuse by suggesting how interdisciplinary cooperation works and what services are available. Few would disagree that from both preventive and curative points of view, treatment of victim, offender, and significant others as well as enforcement of the law are best served by cooperation between social service, law enforcement, mental health, legal, and medical communities. Recent experiences in Massachusetts with Sexual Abuse Intervention Teams and innovations in the courtroom are illustrations of such cooperation. This Manual describes in detail the kinds of services which are provided by organizations in Central Massachusetts.

There are many goals which guide interventions in child sexual abuse from the time of initial disclosure by the child. Because this initial period is often critical in further treatment and/or prosecution of a given case, we offer below some child-oriented goals which we believe result in the most favorable outcomes for victims of child sexual abuse.

1. To immediately protect the child victim.
2. To identify and protect any other "hidden" victims or children who are at risk of the sexual abuse.
3. To stop the sexually abusive behavior.
4. To avoid the further victimization of the child by the family and the "system of intervention."
5. To prevent maladaptive coping strategies of the victim, the offender, and others connected to the victim and offender (for example, substance abuse, running away, prostitution, suicide, etc.)
6. To identify and support the strengths and healthy alliances in the family.
7. To identify and help organize family support for the victim.
8. To refer all family members for crisis intervention, evaluation, and ongoing treatment.

There will often be disagreement among thoughtful people concerning the best means and procedures for implementation of these goals. There are also other goals which some may consider more important than those listed here. This Manual is dedicated to the proposition that only through a hammering out of issues such as these will service providers come to understand the best ways of handling the many facets in the treatment and prosecution of sexual abuse cases.

There are a few issues, however, which we, as mandated reporters, *must* address consistently. The first is immediate reporting of suspected child sexual abuse to the Department of Social Services. The statutory requirement, procedures, and a sample filing form are presented in Section Two of this Manual.

Second, the dynamics of most child sexual abuse cases indicate that we are dealing with multi-troubled families. An effective decisionmaking process is critical given these dynamics which commonly include the "generationally repetitive" nature of sexual abuse, power relationships in the family, shame and guilt, and denial/resistance. Experience is now showing us that decisionmaking processes grounded in interdisciplinary approaches enhance the work that each of us performs separately. No agency or organization listed in this Manual provides *all* of the services required to address the needs of parties in child sexual abuse cases. This Manual provides information which will aid in both intra-agency response to complexity and inter-agency cooperation.

Finally, a few words about what this Manual is *not*. It is not a comprehensive guide to interventions in child sexual abuse. There are many handbooks, articles, and monographs in the professional literature. The Manual is written by professionals for professionals and addresses two principal issues: (1) practices widely used by the various professionals involved in child sexual abuse interventions, and (2) a directory, for Central Massachusetts, of the agencies and organizations with special expertise in child sexual abuse. In addition, the Manual contains technical information, especially in medical and legal areas.

The compilation of the directory section of the Manual occurred in May-June, 1986 by means of a questionnaire mailed to all respondents of an earlier survey* as well as to additional organizations known to members of the Worcester Area Child Sexual Abuse Task Force. The directory does not pretend to be complete. Nor does inclusion of agencies or organizations presented here imply recommendation of the agencies or their programs. For reasons of timeliness, it was not possible to provide the quality assurance procedures which the producers of the Manual would desire for their own programs.

Two terms are used interchangeably in this Manual, sexual abuse and sexual assault. Both terms can imply anything from forcible rape to a "threatening gesture" (the legal meaning of "assault" as in "Assault and Battery"), depending on context.

In order to address issues related to future revisions of this Manual, there are three forms at the end. We encourage readers to give us suggestions on how to keep the Manual useful and current.

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* "An Analysis of the Child Victimization Survey Prepared on Behalf of the Child Sex Assault Task Force." Worcester: The Social Service Planning Corporation, October, 1984.

Distinguished Key Advisors Committee

The Advisory Committee to the Professional Reference Manual Project of the Worcester Area Child Sexual Abuse Task Force has been involved in the work of the Project since its inception. At the first meeting of the Advisory Committee on April 25, 1986, the Project received guidance concerning its principal goals. A general outline for the Manual was developed and major points to be made in the didactic sections of the Manual reviewed. Finally, the type of data to be collected from agencies and organizations which provide sexual abuse interventions was discussed and the best means for data collection outlined.

At the second meeting of the Advisory Committee on June 27, 1986, a draft of the Manual was reviewed by all members. Revisions and procedures for quality control were incorporated into the final version of the Manual. Finally, discussion and plans for a conference on child sexual abuse, at which the Manual would be made public, were outlined.

Members of the Advisory Committee:

Alan Chates
Regional Director
Massachusetts Office for Children

Debra DiPadua
State Trooper
Massachusetts State Police

John Durkin, EdD
Superintendent of Schools
Worcester Public Schools

Thomas Friend
Associate Superintendent for Research & Development
Worcester Public Schools

John Ford
Area Director
Massachusetts Department of Mental Health

Dorista Goldsberry, PhD
Executive Director
Worcester Youth Guidance Center

Hon. Lucian Manzi
Worcester Juvenile Court

Gerald Nugent
Regional Director
Massachusetts Department of Social Services

Robert Sorrenti, MD
Chief of Pediatrics
Worcester City Hospital

Worcester Area Child Sexual Abuse Task Force

Michael E. Donnelly, Esq.
District Attorney's Office
Co-Chairman

Mark Horwitz
University of Massachusetts Medical Center
Co-Chairman

Francella F. Dormitzer
Steering Committee

Susan M. Getman
Massachusetts Society for the Prevention
of Cruelty to Children
Steering Committee

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Lynn Christiansen
Rape Crisis Program of Worcester

Anita L. Collins
Elmwood Counseling Services
The Community Mental Health Center

Robert Consolmagno
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Kathleen Finn, PhD
Worcester Children's Friend Society

Sandra Gottsegen
Massachusetts Office for Children

Bonnie Horka
Health Information and Referral Service

Ron Macon
United Way of Central Massachusetts

Deborah Madansky, MD
University of Massachusetts Medical Center

Michael Mazloff
Health Awareness Services
of Central Massachusetts

Peter Moran, PhD
Boston Road Clinic

Pamela O'Malley
Massachusetts Department of Social Services

Anthony Pellegrini
District Attorney's Office

Katherine M. Plainte
Camp Fire, Inc.

Elizabeth Priestly, PhD
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Susan Quinby
Worcester Youth Guidance Center

Lory Santoro
CAP Project of Greater Worcester

Jeanne Wess
Family Health and Social Service Center

Vivian Zeitz
CASA Project & CAP Project

The Commonwealth of Massachusetts
Executive Office of Human Services
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

MICHAEL S. DUKAKIS
GOVERNOR
PHILIP W. JOHNSTON
SECRETARY

FOREWORD

The Commonwealth of Massachusetts has for many years been at the forefront in developing humane and effective responses to the needs of families in general and of individuals in particular. In the area of child sexual abuse, the "Videotaping Testimony Bill" and the "Mandated Reporters Bill" among others, have set the stage for more effective responses to service provision for all who are affected by child sexual abuse. Reflecting Governor Michael S. Dukakis' support for these efforts, the Commonwealth's Executive Office of Human Services is welding these services into a comprehensive network which attempts to provide the most effective and efficient delivery.

It is extremely heartening, therefore, to see this same degree of effort toward integration of services at the local level. This Professional Reference Manual and the Worcester Area Child Sexual Abuse Task Force which produced it, are examples of the fact that professionals can agree about roles and responsibilities in extremely difficult interventions. Not only will the information which the Manual contains increase knowledge about the resources available in Central Massachusetts, but the process which generated the Manual should also be an inspiration to and a model for those who would like to duplicate it in their own localities. The Manual has been written and reviewed by some forty individuals in the Worcester area representing professions which are commonly involved in child sexual abuse interventions: social service professionals, physicians, educators, law enforcement officers, and the legal professions. In working together on this Manual, these thoughtful professionals have not only brought to bear their own expertise, but have increased their awareness of and respect for that of others.

Although this Manual speaks most directly to Worcester area providers, it can be more broadly applied. For example, the technical information concerning medicine has national applicability, while that concerning law and case management can be used statewide.

A heightened awareness of both child abuse intervention strategies as well as of the agencies and organizations which provide services will contribute to the amelioration of one of modern society's most resistant ills. It is to be hoped that such an interdisciplinary approach will contribute to the quality of life for all Commonwealth citizens.

Sincerely,

Philip W. Johnston
Secretary
Executive Office of Human
Services

Acknowledgements

Many people and organizations have contributed both in-kind and financial support to this project. The Central Massachusetts Area Health Education Center provided major backing for development of the Manual and its design. We offer special thanks to Gail Lewis and Arthur Shapland of the Center.

Data General Corporation assumed responsibility for printing the Manual. Ray Thomas and David Dimmick at the Corporation coordinated the activities there.

Finally, Eric Buch at United Way was involved with the Task Force at its inception and has helped again, with Ron Macon, in final production and distribution of the Manual.

The Manual is the product of the ideas and contributions of many people. They have given unsparingly of their time to Task Force members and to the Project Director in order to improve the usefulness of this Manual to all providers of services in child abuse cases. They should, however, not be held responsible for the views expressed here which are the sole responsibility of the Worcester Area Child Sexual Abuse Task Force. These people represent a broad spectrum of professionals involved in child sexual abuse interventions: Claire Angers, Frances Anthes, Joe Cambray, Paul Caswell, Carolyn Droser, Marcia S. Dudley, Elaine Duquette, Jean Griesheimer, Judy Kraft, Marian MacLean, Christine Millette, Patricia Moran, Joanne Nicholson, Gerald Nowosacki, Elizabeth Nyman, Ellen O'Connell, Mica O'Neil, Zoe Ostrow, Jane Padro, Dr. Sean Palfrey, Elizabeth Price, Don Rosebury, E. Albert Swenson, William Terrill, Miriam Torres, David Van Kennen, and Marianne Winters.

The members of the Worcester Area Child Sexual Abuse Task Force wish to express sincere appreciation and thanks to the Project Director for the Manual, Ted Allen. Without his dedication to the mission of the Project and his consummate skill in executing his responsibilities, this Reference Manual would not have been successfully produced. Above all, Ted has consistently managed to facilitate the critical elements of joint planning, decision making, and concensus building with a diverse group of over forty professionals. His patience, mediation skills, and vision were crucial in enabling our professional community to produce this document.

Also critical to the production of the Manual was the continuous and intensive support provided by Susan Getman and the staff of the Massachusetts Society for the Prevention of Cruelty to Children. Susan was one of the originators of the concept of the Manual and has been consistently dedicated to making it a reality. Her willingness to accept the responsibilities as lead agency for the Project is witness to this dedication. And her thoroughness and skill in providing professional focus and continuity to a complex interdisciplinary undertaking has made this Manual a professional resource of which all of the Task Force is proud.

Finally, the Key Advisory Committee has been a continuous source of guidance to this Project. Their ideas and counsel have strengthened and broadened the perspectives in the Manual. Their support has been critical to the completion of the Project. The Task Force is grateful for this support and professional guidance.

Interdisciplinary Perspectives

If a Child Discloses to You

Signs and Indicators of Sexual Abuse

Considerations for Physicians and Medical Professionals

The Court's Response to Sexual Abuse of Children

Child Sexual Abuse and the Schools

Case Management: Human Service and Mental Health Practitioners

If a child discloses to you

Disclosure of sexual abuse is one of the most difficult things for a child to do. Younger children may disclose accidently not realizing the implications of what they are telling you. Older children tell in a more deliberate fashion, usually just wanting the abuse to stop and not being fully aware of the implications. It is important both to be aware of general reactions (both yours and the child's) and to know what to do.

GENERAL REACTIONS

The child's attitude and feelings: This is a difficult task for children for numerous reasons (fear of what will happen, guilt, embarrassment, etc.). The child is most probably only telling you a small portion of what has happened to them and what more they tell you and/or anyone else will depend to a great extent on your reaction.

Your reaction: Shock, anger, and confusion are all normal reactions to learning that a child you know has been sexually abused. You may have strong feelings about what the child has told you, but it is important not to alarm the child with a strong emotional response. Use fellow colleagues or your supervisor to process your feelings. If for any reason (i.e. you may have been abused as a child) you find it too difficult to talk to the child, get someone to help you or to do it for you.

1. **Can I believe what the child tells me?**

   Yes. Even though teenagers have a wider knowledge base than do younger children, many studies show that nearly all children of any age tell the truth when they disclose. In fact, the initial disclosure frequently underrepresents the extent of the abuse. Even if a child retracts the story, this comes from being fearful of the consequences or from being threatened by the offender. If a child recants, let them know that you understand why this is hard for them, but that you believe what they originally told you. If a child appears confused and doesn't have a logical sequence, remember also that this is understandable. Reassure the child. Let the child know that he/she did the right thing in telling you.

2. **How important is it to get as much information as possible from the child?**

   Don't pump the child for details. Children may only be ready to discuss some parts of the abuse. Pushing too much may only further frighten and confuse the child. It is not your job to gather all the facts in the case.

3. **What if the child takes the blame for the abuse?**

   Let the child know that it is not his/her fault. The child needs to know that the victim is never to blame in cases of sexual abuse. Although it is important to let the child know that the offender is to blame, be careful not to express negative feelings for the offender. Remember that 80% of children are abused by people they know and that they have ambivalent feelings toward the offender.

4. **What are some major sources of this ambivalence?**

   The offender commonly utilizes authority and power (which often masks insecurity and low self-esteem) to involve the child in a sexually abusive relationship. Often the offender will offer the child favors or privileges to "keep the secret," thus setting up conflict between the child and the other parent or siblings. This commonly eliminates sources of safety for the child both prior to and following disclosure.

5. **How can I maintain rapport with the child?**

   Use the child's language and do not put words in the child's mouth. You may think you understand what they are saying, but the child's perception may not be the same as yours. Let the child know that you will do your best to support them. Children need to be protected from further assault. Let them know that you will need to tell other people who can help them keep safe.

6. **How do I decide whether or not to report?**

   If you are a mandated reporter you *must* file a 51-A report with the Department of Social Services. See page 29 of this Manual for a listing of telephone numbers to call.

7. **Should I notify the parents of the child of my report?**

   The factors to consider are numerous, and it may be important to seek consultation before acting. Some factors are: concern that a parent might disappear with the child if informed, presence of the offender in the home, and current therapy and services provided to family members. The ruling consideration is the safety of the abused child. If you believe that the child will be put in jeopardy as a result of informing the parents, you should not do so. At any rate, notify DSS of your decision, and consult with them concerning difficult issues; they deal with such issues all the time and will be glad to answer your questions.

Signs and Indicators of Child Sexual Abuse

Child sexual abuse is sexual contact with a child by an adult or older child. It ranges in behavior from indecent exposure by the offender to fondling and intercourse. A common feature of child sexual abuse is its secretiveness, and it may also involve physical violence.

The one sign or indicator conclusive of sexual abuse in young children is the presence of sexually transmitted disease. Some victims exhibit no signs. Some signs of sexual abuse also are found in other problem areas. Normal childhood and adolescent sexual development further complicate the identification of clear-cut signs of sexual abuse.

If a number of these indicators are observed, however, and they remain consistent over time, there is reason to consider the possibility of sexual abuse.

I. Infants and Toddlers

A. Physical Signs
   1. Trauma to genitals or mouth; genital or urinary irritation and/or venereal disease.
   2. Other bruises, burns, and injuries.
   3. Unexplained sore throats may indicate forced oral sex by the perpetrator.
   4. Unusual and offensive odors, vaginal discharge, penile discharge, and vaginal, penile, or rectal bleeding or laceration.
   5. Complaints of pain or discomfort in genital or rectal area.
   6. Foreign bodies in the vagina, urethra, or rectum.
   7. Developmental delays.

B. Socio-Emotional-Behavioral Signs
   1. Intense fear of people in general and/or of a specific individual or place.
   2. Abrupt changes in behavior.
   3. Sleep disturbances (bedwetting, nightmares, and insomnia).
   4. Withdrawal and/or depression.
   5. Developmental delays.

II. Pre-School Children

All of the signs above and:

A. Physical Signs
   1. Bedwetting.
   2. Pants wetting, soiling.
   3. Regressive behavior (e.g thumbsucking).
   4. Hyperactivity - should be screened for sexual abuse.
   5. Somatic complaints - chronic headache, abdominal pain, constipation.

B. Socio-Emotional-Behavioral Signs

1. Sudden change in behavior.
2. Child's direct or coded statement indicating sexual hurt.

C. Sexualized Behaviors

These especially need to be considered in light of normal child sexual development.

1. Excessive masturbation.
2. Sexualized kissing, thrusting.
3. Sexual acting out with siblings or peers.
4. Precocious knowledge of sexual activities.
5. Excessive sexual curiosity.

III. School-Aged Children

All of the above and:

1. Disturbed peer interactions.
2. Change in school performance; inability to concentrate, drop in grades, truancy, and tardiness.
3. Mistrust of adults in general.
4. Depression, withdrawal, sadness, listlessness.
5. Sleeping disorders - nightmares, insomnia.
6. Inappropriate dress and dirty or torn clothing.
7. Early arrival and late departure from school.
8. Avoidance of physical activity and undressing.
9. Expression of inappropriate caretaker behavior toward parents.

IV. Adolescents

All signs listed above and:

1. Self destructive activity or suicidal thoughts; self inflicted injuries like cigarette burns.
2. Eating disorders (particularly bingeing and purging) and overeating.
3. Delinquent behavior and/or running away.
4. Drug and alcohol use.
5. Early pregnancy.
6. Prostitution, promiscuous behavior, or other unusual sexual behaviors.

Considerations for Physicians and Medical Personnel

1. Become familiar with the wide range of physical and behavioral presentations of sexual abuse, and maintain a high index of suspicion for them throughout your clinical practice.

2. If you suspect sexual abuse, or if you are the first professional to which a family has turned for suspicion of sexual abuse, you should perform or arrange for the performance of a comprehensive evaluation including appropriate interviews, physical examination, and determination of disposition. Remember that you will be serving as the child's advocate in the process. Timeliness is an important consideration.

3. If you are serving as a consultant after the disclosure and investigation of sexual abuse, you should provide the services requested (usually a physical examination) and screen other aspects of the child's functioning.

4. History:

    a. Obtain the history of the alleged incidents from the parent(s) alone, and document this in your records.

    b. Document any other current complaints and ask about the presence of signs and symptoms which can suggest or accompany sexual abuse.

    c. Obtain a history from the child alone, and note the child's own words in your records.

    d. Realize that an inability to obtain the history from the child does not rule out sexual abuse.

5. Examination:

    a. Perform a complete physical examination instead of concentrating only on the genitalia (see Section Four on *The Medical Examination*). This allows the establishment of further rapport with the child in a familiar context, and allows you to look for signs or symptoms of physical abuse or neglect in addition to sexual abuse.

    b. Document all normal findings, signs of infection, and injury.

    c. Reassure the child and family about normal findings, since the family members are often quite upset, and children may feel that they are "damaged goods."

    d. A normal physical examination does not rule out sexual abuse. The majority of children who have been sexually abused have no physical findings.

6. Laboratory:

   a. Appropriate lab tests and cultures should be sent. (See Section Four, *The Medical Examination*, for details).

7. Disposition:

   a. Work aggressively with other agencies to protect the child from further abuse. Such protection may involve admission to the hospital if no other safe disposition of the child is possible.

   b. If you have reasonable suspicion of abuse or neglect, file a 51-A form with the appropriate area office of the Department of Social Services.

   c. Treat all injuries, signs, and symptoms appropriately.

   d. Arrange medical follow-up if necessary.

   e. Arrange psychological assessment and follow-up.

   f. Whatever the outcome, take the opportunity to educate the family about prevention.

The Court's Response to Sexual Abuse of Children

Introduction

When confronted by sexual abuse, children and those who care for children need support and information in deciding how best to respond to that abuse. To help in those decisions, children and families should know that the courts of the Commonwealth of Massachusetts provide a wide range of responses to this abuse. Because of the facts unique to each case, such as the age of the child involved or the relationship of the child to the offending person, the court's reponse will differ. What is common to all cases of child sexual abuse is the need for children and families to know that they are not without choices and some measure of personal control in working with the courts.

This sense of personal control and options can be an important first step in the healing process for those who have been abused and in the best outcome possible from the court process. The four areas of court involvement in this matter are as follows:

1. The Probate Court - A non-criminal court that can, when the victim and the abuser are of the same household, order the abuser to have no contact with the child. This court can in family matters decide issues concerning who will have custody of the child and what rights, if any, a relative who is an offender will have in visiting with the child.

2. The Juvenile Court - A non-criminal court that is concerned with the care and protection of children. Issues of removal of children from abusive households and protection of children from that abuse are decided in this court. Treatment and supportive services for children can be required by this court, and parents' rights to contact with their children can be allowed or disallowed.

3. The Criminal Courts - The District Courts and Superior Courts provide the forum for criminal actions against those suspected of having committed crimes of sexual abuse of children. The Worcester County District Attorney's Office is responsible for investigation and, when appropriate, prosecution of all criminal matters.

4. Civil Tort Action - People can bring civil (non-criminal lawsuits usually seeking payment of money to victims for injuries) against individuals or groups responsible for injuries occurring in sexual abuse situations. Though rarely resorted to, this option does exist for children and families. If persons are interested in pursuing this option, they should contact private practicing attorneys.

CHILDREN:

1. **If I report a case of child sexual abuse will my child have to testify?**

   Rarely, if ever, do children testify in Probate and Juvenile Court proceeedings. In criminal cases children are often called upon to testify. Such testimony does not always have to be presented in the courtroom or in the presence of the alleged offender. The testimony can be in electronic (videotape) form and used as evidence in the courtroom (see the section on *Massachusetts Statutes*).

2. **What help will my child receive if he/she is called to testify?**

   The District Attorney's Office maintains a Victim/Witness Program with trained staff who specialize in supporting children and families through the court process.

3. **Will my child and I have any say in the criminal process?**

   Yes. If children are experiencing threats from an offender or if they are physically or emotionally unable to testify, the District Attorney's Office should be informed. If the person who abuses your child pleads guilty, or after the trial is found to be guilty, you or your child have a right to address the judge on what you would like to see happen in this case, such as punishment or treatment.

THE OFFENSE:

4. **If the offense occurred a long time ago can this case still come to court?**

   It depends on when the offense occurred. If your child has been raped, the statute of limitations (time in which a charge can be brought) is ten years. If your child has been indecently assaulted (improperly touched in a sexual way), the statute of limitations is six years.

5. **What is rape?**

   The penetration against the will of a person's vagina or rectum by a penis or other object as well as the penetration against a person's will of a person's mouth by another person's penis, or the taking of another person's penis into one's mouth against the victim's will.

6. **What is indecent assault and battery?**

   The touching without consent of a person's genital areas, rectum, or breasts.

7. **As the reporter of sexual abuse will I have to testify?**

Not necessarily. In some cases, the person who first was told of the sexual abuse may be called to testify. This possibility comes up infrequently, and, in no case, should it be a reason for not reporting.

REPORTING ABUSE:

8. **Am I liable for not reporting or reporting suspected child sexual abuse?**

Mandated reporters *must* report suspected child abuse (see the list of Mandated Reporters in the *Massachusetts Statutes* section). Failure to report can result in a fine of $1,000. Massachusetts courts have found no liability for good faith reporting of child sexual abuse.

TIME:

9. **How long will this process take?**

The case from start to finish may take from six months to a year. Probate and Juvenile Court may be completed in less time.

10. **How can I keep my child from seeing the father/mother who abused him/her?**

Contact the Probate Court concerning a termination or limitation of visits from an abusing parent.

FACTS:

There is no minimum age limit that bars a child from testifying in Massachusetts, but children must be found competent (able to tell the truth from a lie and to swear or promise that they will tell the truth).

Cases in Probate Court concerning custody and visitation are subject to being appealed or modified even after final orders have been entered.

Many cases are not prosecuted because the children involved are unable or unwilling to testify. These cases are often handled in the Juvenile and Probate Courts where non-criminal solutions can often be obtained.

Prompt medical examination of child victims should always be considered. In addition to possibly helping in the handling of the court case, the child and non-offending parents need to be reassured concerning medical status.

ADDRESSES AND PHONE NUMBERS:

Worcester County District Attorney's Office
757-2786
To report child sexual abuse and to request that a criminal investigation be conducted.

Worcester Probate Court
756-2441
To request a complaint for protection from abuse. To seek termination or limitation of parental visitation rights.

Department of Social Services
791-1200 or 1-800-922-8169
To report a case of child sexual abuse. To secure a care and protection hearing on child safety.

Worcester Juvenile Court
791-7109

Worcester County Bar Association
Lawyers Referral Services
752-1311

CONCLUSION:

Children and those who provide care for them should know that they can be heard and have a say in what will happen in child abuse cases. In addition, there is flexibility in this system for children's protection through various routes, including the Probate, Juvenile, and Criminal Court settings. The rights of children to protection from abuse are considerable, but they must be balanced against those of the accused in criminal court, and those of parents in juvenile and probate courts. Ask questions and advocate for the children throughout the process. Legal representation, though not universally required, can help in this process. Above all, parents and children should ask questions and make the courts work as well as possible for them.

Child Sexual Abuse and the Schools

A school-aged child spends about one third of his or her total time or one half of awake time in school during the school year. Teachers, counselors, school nurses, and administrators are in a position to spot the signs and symptoms of child sexual abuse with a clinically objective eye and a perspective that can be uniquely insightful. Many first disclosures occur at school which makes school personnel important in the reporting of sexual abuse cases.

Dealing with a student who has disclosed or who shows signs or indicators of sexual abuse need not be difficult for school personnel. Although the time demands placed on educating many children often interfere with devoting additional time to such matters as reporting abuse, it is essential that suspicions of abuse be addressed when they occur. If they are not, the student's progress in school will be impeded and the ability to perform to capacity threatened.

It is important to understand that all reporters who suspect child sexual abuse and file a 51-A report are protected from civil and criminal action by law. Time is of the essence when abuse is suspected.

The following guidelines are recommended for school personnel:

1. Discuss suspicions with the school guidance counselor or other designated individual on the day you first suspect abuse. Such a person may be aware of issues that clarify your suspicions (either supporting or negating them).

2. The guidance counselor and the person who suspects the abuse (e.g. teacher) should contact the principal. If the principal is absent, the individual assuming the principal's responsibilities on that day should be contacted.

3. This group then decides whether other professionals (e.g. school nurse or psychologist) should be contacted so as to provide additional information and perspectives.

4. The decision whether or not to file a report to the Department of Social Services must be made as soon as possible. If a team approach is used in making this decision, it may occur that unresolvable differences will inhibit filing as a team. It is important to note, however, that each team member by law is a mandated reporter in his or her own right. (see the Amendments to the 51-A law on page 132 of this Manual).

5. School personnel involved with the student should work with parents and/or guardian as well as the Department of Social Services in following up the case.

The post-disclosure period can be difficult for the victim, other students, and siblings. Certain periods require special sensitivities, such as the time surrounding publicity concerning the case, or the time of court proceedings.

These times are also difficult for those who work regularly with the victim and his/her family and peers. School personnel should be especially supportive of their colleagues who are most directly affected by their daily contact with such children and their families.

RECORD KEEPING IN THE SCHOOL

1. School personnel should keep their own log of suspected cases with date, notations of injuries or other signs in order to document repetitive actions.

2. The 51-A Form (which must be completed and mailed within 48 hours of the oral report) should be kept in the student's cumulative folder and sent to the new principal when a change occurs. If the parent(s) requests removal from the record when released to out-of-state transfer, the principal may call DSS and request an interstate referral to alert school and agency if a reportable condition still exists and the child is at risk.

3. A DSS worker can receive reports even if a parent objects to their release. The Student Record Law is superceded by the DSS regulation providing access without parental release within 7 days of the 51-A report. After 7 days, release is necessary.

4. Should a case be closed by DSS and school personnel remain convinced that the child is sexually abused, the reporter may reinitiate a 51-A. If action is not forthcoming, the person can register a complaint with the District Attorney. If a new situation of sexual abuse arises involving a child who is alrady being served by DSS, a new 51-A must be called into DSS.

Case Management: Human Service and Mental Health Professionals

Human service providers, and many mental health professionals, are accustomed to working through the establishment of networks and cooperative, often multi-disciplinary, relationships among services and organizations. It is often within these networks that disclosures of sexual abuse occur. This raises questions as to which provider should file reports and which provider should follow through with case management.

When a human service provider or mental health professional has reason to believe that a child has been sexually abused, *a 51-A report must be filed*, because all professionals in these fields are identified by law as *mandated reporters*. While it is true that filing such a report can raise difficult treatment and/or case management issues, ensuring the child's safety and protecting the child from further abuse is of paramount importance.

Within the context of an agency or organization, it is often the case that sexual abuse will be disclosed to two or more workers at about the same time; for example, a parent and a child might each disclose an incident of sexual abuse to their individual therapists. Often this situation will raise questions as to which provider should file the 51-A report. All providers should file.

There are also times when several agencies or organizations are involved with a family and may be made aware of the abuse simultaneously. In all such cases, the issue of filing, case management, etc. arises. When several individuals have been made aware of sexual abuse, therefore, it is also often advisable to file a joint report thereby presenting a "united front."

Whatever the decision made, it must be made quickly because the reporting of sexual abuse cannot be delayed for the sake of ensuring that all of the possible clinical implications have been explored at length.

Private practitioners, not working in groups, face a different set of problems. First, knowledge of how and where to file is often incomplete. Questions, which others working in group contexts ask of their colleagues, often go unanswered for the solo practitioner. The Department of Social Services can be consulted directly when questions arise. Page 29 of this Manual contains locations and telephone numbers.

In addition, because private practitioners are more accustomed to dealing with problems by themselves, it is tempting for them to see sexual abuse, (especially in cases where the offender is a family member) solely as a treatment issue which can be resolved with the appropriate therapeutic intervention. Many therapists find the reporting of sexual abuse difficult because it is antithetical to the maintainance of confidentiality between therapist and client. Yet, by law, the Department of Social Services *must* become involved in the management of the case. Some clinicians choose to prepare their clients for such an eventuality by telling them at the outset of therapy that there could be situations involving the safety of the client and/or others, under which strict confidentiality could not be kept.

It is important to note that filing a 51-A does not put the reporter in jeopardy. Massachusetts statute clearly protects mandated reporters. Even in this age of frequent litigation, you are legally protected and will not be held liable for civil or criminal action if you file a 51-A. All you need to ask yourself is: do I have reason to believe that neglect or abuse has occurred.

A common complaint among human service providers is that once the report is filed with the Department of Social Services, there is often inadequate feedback to the reporter of the progress of the investigation. This can become a particularly important concern when the client's interaction with the provider/reporter will be directly affected by the investigation.

The Department of Social Services, however, screens large numbers of reports on a daily basis. It is not always a simple task to communicate with all reporters, or to discriminate between what is privileged information and what is not. The provider has an official responsibility to the client as an advocate and should ensure follow-up of the case and participate in the development of treatment plans. Reporting sexual abuse implies a partnership between the reporter and the investigating agency.

1. **What if two, or more, human service providers are simultaneously aware of suspected abuse?**
   Time is of the essence in filing 51-A reports, and all providers should file. It is also possible to file as a team.

2. **What if a mandated reporter is not sure whether what is observed constitutes sexual abuse?**
   Call DSS and ask their opinion. You can call anonymously, and DSS staff are well trained regarding this issue.

3. **What if you are not contacted by DSS after you file a 51-A?**
   By regulations DSS is required to notify you of their screening decision and the investigation outcome. As a professional, however, you have as much responsibility as DSS does in monitoring the course of your report. Call them.

4. **What if you fear that the child's living situation will become worse if you report?**
   You are a mandated reporter, and you must report. You and DSS should work together to make the best of what might become a bad situation.

5. **Do you inform the parents or caretakers that you will report suspected abuse?**
   If it will not place the child in jeopardy, you usually do. If you are concerned that the parents will increase the abuse after hearing about the report, you may wish to protect the child in the short run by not telling the parents. If you are unsure, first consult DSS and/or other providers of service to the family. In any case, inform DSS of your decision.

Intervention Scenarios

Mandated Reporting of Child Sexual Abuse: The 51A Report

Intervention Scenarios I: What Can Happen to Victims

Intervention Scenarios II: What Can Happen to Offenders

Intervention Scenarios III: What Can Happen to Families

Case Histories

Mandated Reporting of Child Sexual Abuse: The 51-A Report

The Massachusetts General Laws, Chapter #119, 51-A and 51-B, mandate that the Department of Social Services receive reports of child abuse and neglect, including those of sexual abuse, and investigate such reports within seven calendar days. Emergency reports are investigated within 24 hours. All investigations are carried out under the policy of the Commonwealth of Massachusetts which is to "strengthen and encourage family life, so that every family can care for and protect its children." To this end, the Department will make every reasonable effort to serve a family as an intact unit while also intervening to protect the rights of children should the parents not be able to provide the necessary care and protection. This is a difficult balance to achieve, but it is the mandate to the Department in delivering all services.

The Law requires that any mandated reporter, who in his or her professional capacity shall have reasonable cause to believe that a child under the age of eighteen years is suffering serious physical or emotional injury resulting from the infliction of sexual abuse, shall immediately report that condition to the Department. The Department defines sexual abuse very broadly. Most reports generally fall within one of the following three categories:

1. Sexual Assault - rape, molestation, fondling, attempted sexual contact, etc.
2. Sexual Exploitation - encouraging a child to engage in prostitution or the obscene or pornographic photographing or filming of a child.
3. Inappropriate exposure of a child to sexual behavior or materials.

Additionally, the perpetrator of the alleged sexual abuse must be a 'caretaker' to the child. Although interpretations of the meaning of caretaker may vary, the definition generally broadly includes any person entrusted with responsibility for the child in the child's home, a relative's home, a school, or other place where the child frequents. Thus the meaning of 'caretaker' is construed broadly and includes babysitters, school teachers, school bus drivers, and camp counselors. When the Department receives a report where the alleged perpetrator is clearly not a caretaker, it will be referred to the local police department. The Department will accept reports even if *no* alleged perpetrator is identified or where the perpetrator is unknown.

The Reporting Law contains general provisions which each mandated reporter should be aware of. First, knowledge of child sexual abuse on the part of a mandated reporter can never be considered confidential and privileged communication and thus not reported to the Department. Secondly, the Law provides mandated reporters with statutory immunity from legal liability, either civil or criminal, brought against them for making a report. Third, failure by a mandated reporter to make a required report is punishable by a fine of not more than one thousand dollars. Last, although the Department encourages mandated reporters to inform families of the need to file a report and the reasons why, the Department will not release the reporter's name to anyone. However, anonymity from the family cannot be guaranteed because the Department may be ordered to reveal the reporter's name if there is a subsequent court action.

DSS Protective Intake Policy states:

"The purpose of screening is to determine, based on the facts in the report, whether there is or may be reasonable cause to believe that a child(ren) has been abused or neglected or may be at risk of being abused or neglected by a caretaker. Screening includes consultation with the reporter, Department files (including the Central Registry), and any collateral contacts that may be able to provide corroborative information specific to the reported incident, the child(ren)'s condition, or to assist in determining the initial response. Screening is a key part of the overall process of reporting, identifying, assessing and providing treatment for families and children. It is that part of the process which determines the Department's subsequent actions and intervention with the family."

When making a report to the DSS Protective Screening Unit, you will be asked to give the following information:

1. The name(s), address, present whereabouts, date of birth or estimate of age, and sex of the reported child(ren) and of any other children in the household.
2. The names, addresses, and telephone numbers of the child's parents or other persons responsible for the child's care.
3. The principal language spoken by the child or the child's caretaker.
4. Your name, address, telephone number, profession, and relationship to the child (non-mandated reporters may request anonymity).
5. The full nature and extent of the child's injuries, abuse, or neglect.
6. Any indication of prior injuries, abuse, or neglect.
7. An assessment of the risk of further harm to the child, and if a risk exists, whether it is imminent.
8. The identity of a third party, if any, who gave you any information concerning the case, unless anonymity is requested.
9. The circumstances under which you first became aware of the child's alleged injuries, abuse, or neglect.
10. The action taken, if any, to treat, shelter, or assist the child.

Note that mandated reporters must follow-up a verbal report by a written 51-A report within 48 hours (the 51-A form is reproduced on pages 33 and 34 below).

The purposes of investigation are to determine if there is evidence to believe that a child(ren) has been or may have been abused or neglected or may be at risk of being so by a caretaker, and to protect the child(ren) from further abuse and neglect. Investigation includes: meeting with the parent(s) or parent substitute(s), seeing and interviewing the reported child(ren) and his or her siblings, consultation with collateral contacts, and a determination as to whether there is reasonable cause to believe that abuse and/or neglect has occurred, including the identification of the alleged perpetrator(s), if any are named. Determination of the nature of the Department's involvement is predicated on this investigation.

Certain substantiated reports are referred to the District Attorney's Office by the Regional Director of the Department of Social Services. In the case of sexual abuse, all substantiated reports where a child has been sexually assaulted and/or sexually exploited fall into this category.

To make a report of sexual abuse, you should first telephone a DSS Protective Screening Unit. In Region II there are five Area Offices and the report should be filed with the office in which area the child resides.

Fitchburg - Area 6 - 345-2101
Ashby, Ayer, Berlin, Bolton, Clinton, Fitchburg, Groton, Harvard, Lancaster, Leominster, Lunenburg, Pepperell, Shirley, Sterling, Townsend.

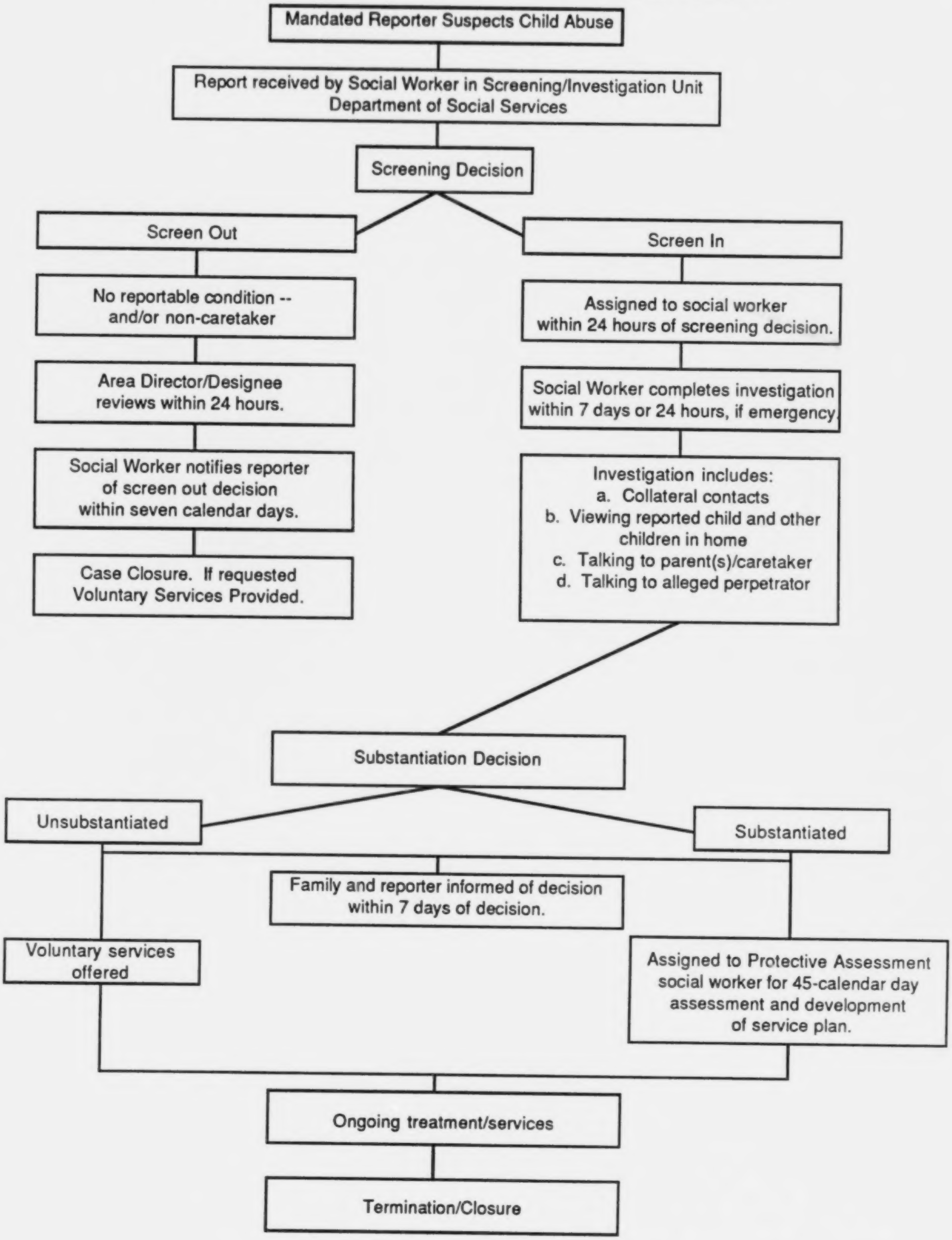
Gardner - Area 7 - 632-9104
Ashburnham, Barre, Gardner, Hardwick, Hubbardston, New Braintree, Oakham, Princeton, Rutland, Templeton, Westminster, Winchendon.

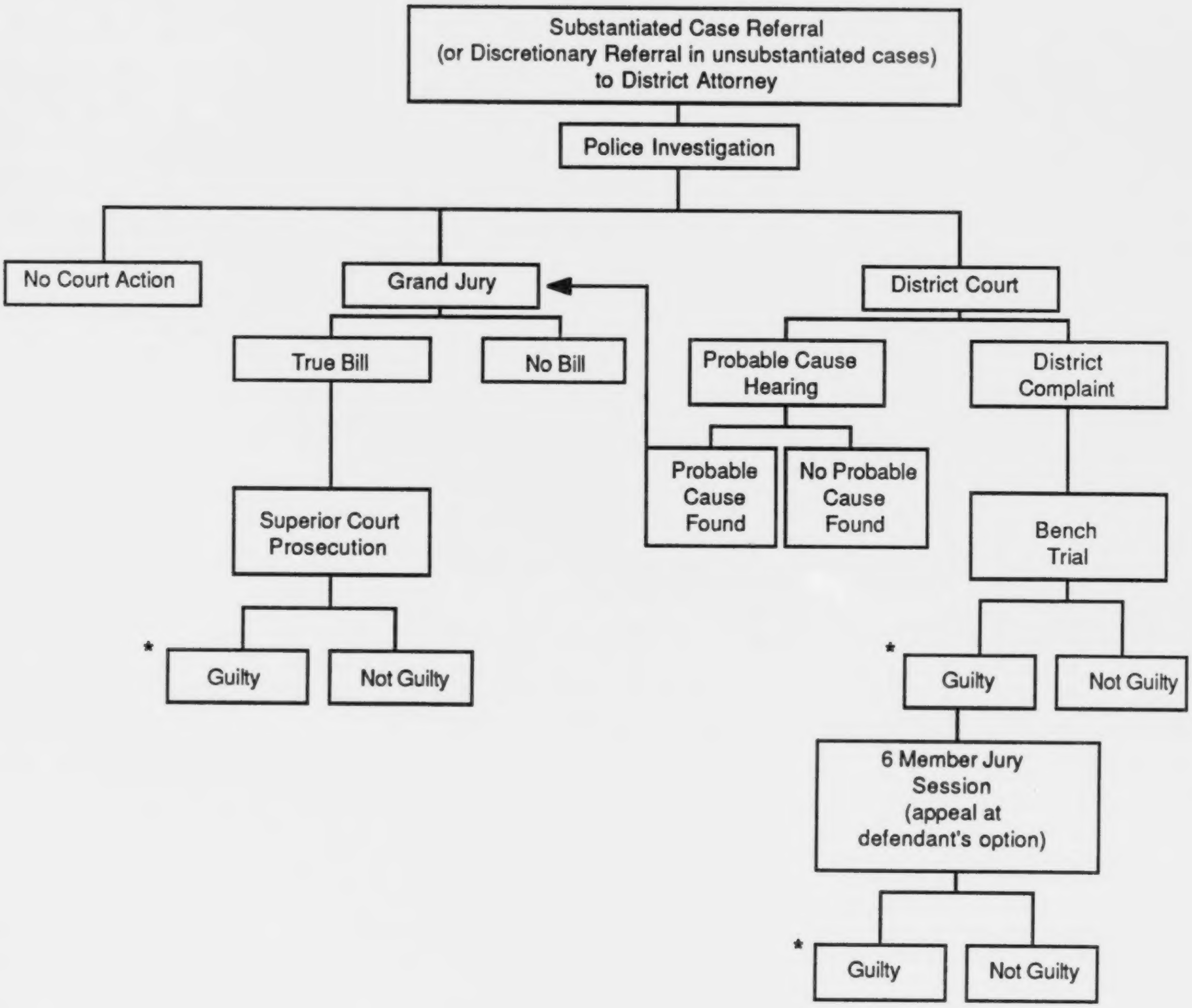
Blackstone - Area 8 - 234-6213
Bellingham, Blackstone, Douglas, Franklin, Grafton, Medway, Mendon, Milford, Millbury, Millville, Northbridge, Sutton, Upton, Uxbridge.

South Central - Area 9 - 949-0113
Brimfield, Brookfield, Charleton, Dudley, E. Brookfield, Holland, N. Brookfield, Oxford, Southbridge, Spencer, Sturbridge, Wales, Warren, Webster, W. Brookfield.

Worcester - Area 10 - 791-1200
Auburn, Boylston, Holden, Leicester, Paxton, Shrewsbury, W. Boylston, Worcester.

FLOW OF SERVICES AND DECISION-MAKING FOR VICTIMS AND OFFENDERS IN WORCESTER COUNTY


Mandated Reporter Suspects Child Abuse
Report received by Social Worker in Screening/Investigation Unit Department of Social Services
Screening Decision
Screen Out
Screen In
No reportable condition -- and/or non-caretaker
Area Director/Designee reviews within 24 hours.
Social Worker notifies reporter of screen out decision within seven calendar days.
Case Closure. If requested Voluntary Services Provided.
Assigned to social worker within 24 hours of screening decision.
Social Worker completes investigation within 7 days or 24 hours, if emergency.
Investigation includes:
a. Collateral contacts
b. Viewing reported child and other children in home
c. Talking to parent(s)/caretaker
d. Talking to alleged perpetrator
Substantiation Decision
Unsubstantiated
Substantiated
Family and reporter informed of decision within 7 days of decision.
Voluntary services offered
Assigned to Protective Assessment social worker for 45-calendar day assessment and development of service plan.
Ongoing treatment/services
Termination/Closure


Substantiated Case Referral
(or Discretionary Referral in unsubstantiated cases)
to District Attorney
Police Investigation
No Court Action
Grand Jury
District Court
True Bill
No Bill
Probable Cause Hearing
District Complaint
Probable Cause Found
No Probable Cause Found
Superior Court Prosecution
Bench Trial
*
Guilty
Not Guilty
*
Guilty
Not Guilty
6 Member Jury Session (appeal at defendant's option)
*
Guilty
Not Guilty

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* Case Disposition most commonly includes: (1) sentence to jail with probation and with mandate for treatment, (2) suspended sentence with probation and mandate for treatment, (3) split sentence jail and probation with mandate for treatment.

COMMONWEALTH OF MASSACHUSETTS - DEPARTMENT OF SOCIAL SERVICES

REPORT OF CHILD(REN) ALLEGED TO BE SUFFERING FROM SERIOUS PHYSICAL OR EMOTIONAL INJURY BY ABUSE OR NEGLECT

Massachusetts law requires an individual who is a mandated reporter to immediately report any allegation of serious physical or emotional injury resulting from abuse or neglect to the Department of Social Services by oral communication. This written report must then be completed **within 48 hours** of making the oral report and should be sent to the appropriate Department office.

Please complete all sections of this form. If some data is unknown, please signify. If some data is uncertain, place a question mark after the entry.

DATA ON CHILDREN REPORTED:

	NAME	CURRENT LOCATION/ADDRESS	SEX	AGE OR DATE OF BIRTH
1)			☐ Male ☐ Female	
2)			☐ Male ☐ Female	
3)			☐ Male ☐ Female	
4)			☐ Male ☐ Female	
5)			☐ Male ☐ Female	

DATA ON MALE GUARDIAN OR PARENT:

Name: ______________________
First Last Middle

Address: ______________________
Street and Number City/Town State

Telephone Number: ____________ Age: ____________

DATA ON FEMALE GUARDIAN OR PARENT:

Name: ______________________
First Last Middle

Address: ______________________
Street and Number City/Town State

Telephone Number: ____________ Age: ____________

DATA ON REPORTER/REPORT:

____________ ☐ Mandatory Report ☐ Voluntary Report
Date of Report

Reporter's Name: ______________________
First Last

Reporter's Address: (If the reporter represents an institution, school, or facility please indicate.)

____
Street City/Town

____________ ____________ ____________
State Zip Code Telephone Number

Has reporter informed caretaker of report? ☐ YES ☐ NO

ABUSE/NEGLECT REPORT - 3 (Revised April, 1983)

What is the nature and extent of the injury, abuse, maltreatment or neglect, including prior evidence of same? (Please cite the source of this information if not observed first hand.)

What are the circumstances under which the reporter became aware of the injuries, abuse, maltreatment or neglect?

What action has been taken thus far to treat, shelter or otherwise assist the child to deal with this situation?

Please give other information which you think might be helpful in establishing the cause of the injury and/or the person responsible for it. If known, please provide the name(s) of the alleged perpetrator(s).

Signature of Reporter

What Can Happen to Victims

For victims of sexual abuse, finding assistance can be both confusing and frustrating. Nonetheless, the victims of sexual abuse have the right to receive support and services that are respectful of their particular needs and situations. It is important to remember that child sexual assault is never the fault of the victim. Child sexual assault is traumatic, and there are social service agencies and governmental organizations available to help with the healing process. After sexual abuse has been disclosed, the victim and his or her family may expect the following types of services to be available to them: crisis intervention, counseling (long and short term), advocacy through the legal, medical, and social systems, and protective services.

When child sexual abuse has been disclosed, and the alleged offender is a caretaker or there is no identified offender, the 51-A process commences. At this point there is an evaluation by the social worker of the abuse victim's need for immmediate intervention. Crisis intervention is available to victims regardless of the length of time which has passed since the assault. The need for crisis intervention around a sexual assault may arise immediately after an assault or may recur up to many years afterward. Either could be triggered by many events. A non-exhaustive list includes a disclosure by someone else, a movie or television program, a realization that someone looks like the offender, or stress unrelated to the assault but which leads the victim to feel that support is needed. This stress is a normal part of the healing process during which the victim needs supportive help. A crisis may also occur immediately after a disclosure because of decisions which need to be made regarding counseling, legal issues, and child protection. The purpose of crisis intervention is to help the victim and family protect the child from further victimization and regain the ability to make informed decisions by providing information about resources as well as emotional support.

As the DSS investigation process unfolds, the victim's circumstances are once again reviewed to determine the need for crisis intervention. This review is then used to plan further intervention.

As part of the investigative process, a medical examination is advised for both evidenciary purposes and safeguarding the victim's health. A medical advocate (nurse, rape crisis counselor) can assist the victim by providing information about the examination and may accompany the individual to the examination. If the victim wishes, the advocate can also be present during the examination itself. A medical advocate can let the victim know step-by-step what takes place during the exam. The advocate can assist the victim in asking difficult questions and in remembering follow-up information.

Depending on the risk of violence to the child victim, legal advocacy may be pursued to protect the child. This may result in a court action to remove either the child or the abusive household member from the home. The victim or caretaker may choose to have an advocate's advice and direction throughout the court process. Advocates (DSS Workers, Rape Crisis Counselors, Victim/Witness Advocates, etc.) provide information about the legal system and all steps of the investigative process so that the victim and family can make informed decisions about legal issues. An advocate may serve as escort to the police station, to pre-trial hearings, and to court appearances. Advocates also serve as liaison between the victim and legal personnel by providing information concerning trial dates, names of attorneys, and general orientation to the court process. A legal advocate can also provide emotional support before, during, and after court cases.

Following the DSS investigation, a case is either substantiated or unsubstantiated. If substantiated (and in some exceptional cases when unsubstantiated) all sexual abuse cases are reported to the District Attorney's Office. Service plans are reviewed by the assigned social worker and appropriate referrals are made for each individual to community agencies. In those cases when there has been substantiation, but where prosecution is not an option, and/or the family is unwilling to participate in service, the social worker will try to provide a supportive alliance with the family.

Regardless of the outcome of a report of child sexual abuse, the idea of short term or long term counseling should be explored with the family because the investigation alone has been traumatic to those involved. Counselors can help by establishing a relationship with a victim of sexual abuse which will allow the person to express feelings more readily. Victims may experience a wide range of feelings and emotions. A counselor can further assist victims in letting them know that child sexual assault is not their fault. Counselors also assist victims in further developing coping skills and in regaining control over their lives.

Once the case has been reported to the District Attorney's Office, an interdisciplinary team is convened. The team is composed of a representative of the District Attorney's Office, a DSS reprepresentative, and a member of a social service agency (for example CASA, MSPCC, etc.). The team discusses treatment and law enforcement issues raised by the case, and the most effective ways to coordinate those effort.

The case is then sent to the police to be investigated. An investigation is conducted during which the victim is interviewed by a police officer to obtain a statement relating the facts of the incident(s). This investigation may be done separately from a DSS interview. Increasingly more cases are now being jointly interviewed by the police and DSS in the countywide Sexual Abuse Intervention (SAIN) Teams. If sufficient information is obtained, either a complaint is sought from the Clerk-Magistrate of the local District Court or the case is directly presented to the Worcester County Grand Jury. No complaint is sought, of course, if the police judge the information received to be insufficient.

From here the case enters one of two processes in the trial courts. In the majority of sexual abuse cases (Rape of Child) a three step process ending in the Superior Court occurs. This process begins with a probable cause hearing in the local District Court. The victim is required to testify at this hearing and is also subject to cross-examination by the defense. If the judge is presented with enough evidence to make a finding of probable cause, the case then proceeds to the Grand Jury where the victim again is required to provide testimony. In this instance, however, the defendant and his/her lawyer is not generally present; there is no cross-examination. The Grand Jury then votes either to indict or not to indict the defendant on each particular offense. Lastly, the case proceeds to the Superior Court where the victim, during a trial, may testify and be subject to cross-examination again. It should be noted that there is always the possibility that a defendent offer a plea of guilty at any stage of these proceedings.

The second process that may be followed is retention of jurisdiction of the case in the local District Court. Some cases (Indecent Assault and Battery, for example) are handled by a trial before a judge in the local District Court or a trial in the 6 member jury session of the District Court. In either case, a child victim is again required to provide testimony and be subject to cross-examination (a summary of the court process is given on pages 30-31 of this Manual).

At each phase of either process, the victim and family members can be assisted by a victim advocate from the District Attorney's Victim/Witness Assistance Program. The advocate is available to provide short-term counseling, referral information, and any other assistance. The advocate is also available to assist in the preparation of a victim impact statement. In this statement, a victim or parent can express to the presiding judge their feelings about the effects of the case on them and their thoughts on sentencing. This statement is only made in the event of a guilty finding by a judge or jury, or a guilty plea by the defendant.

What Can Happen to Offenders

Recent studies of known offenders show that 90% are male and 10% of this population are female. Clearly the vast majority of offenders are male. It is important, however, that a child's disclosure of sexual abuse by a female not be discounted, minimized, or ignored.

Similarly, it is most common to hear of an *adult* sexually abusing a child. Many adult offenders, however, report that their first offense was while there were adolescents. Sexual abuse of a child by an older child or an adolescent should not be dismissed as merely 'experimentation,' but dealt with seriously, because the youthful offender is desperately in need of help. In fact, it is recommended that the youthful offender be interviewed with regard to his/her own history because 80% of offenders report having been victims of child sexual abuse themselves. The issues surrounding their earlier childhood victimization are thus heightened by the disclosure of their own assaultive behavior.

The disclosure of child sexual abuse precipitates a crisis for all those individuals involved, no less so the offender. The offender may respond to the allegations with complete denial. He or she may minimize the allegations, admitting only to 'lesser charges' or that 'no harm was done.' In fewer cases, the offender may admit to being sexually abusive and immediately request help. In any event, it is critical to understand that the disclosure of sexual abuse, in and of itself, will not necessarily result in the offender's stopping the abusive behavior.

The post-disclosure period may be marked by the offender repeating or attempting to repeat the sexual abuse. The offender may threaten or plead with the child, pressuring the child to recant and hoping to reimpose the 'secret.' The offender may also become entrenched in behavior patterns which reflect a false belief that he/she can 'fix' things by being 'good.' It is important to recognize that such behavior is temporary.

Crisis intervention for the offender during this period is critical. The offender often needs to be assessed for such possibilities as a severe depressive reaction, suicidal ideation/attempt, or homocidal threat. With prompt intervention and skillful confrontation, some offenders are able to reverse their initial denial, admit to the charges, and seek treatment.

In evaluating the offender and intervening to protect the child victim, it is important to take note that about half of offenders are later found to have sexually abused multiple children. These children may be siblings of the first victim, friends of the victim, relatives, or children whom the offender has been in contact with elsewhere in the community.

The practice of requiring the offender to cease contact with the child victim immediately upon disclosure is increasingly common. This allows the family more effectively to protect the child from continued abuse, and from the threat of coercion by the offender.

The crisis for the offender may intensify because of the necessity to cope with isolation, family rejection, criminal charges, publicity, and possible repercussions at the workplace. As mentioned earlier, close monitoring of his ability to manage effectively these stressors is important. The rapidity with which mental health and social service professionals are able to begin to evaluate and treat the offender is frequently affected by the legal and court process.

Most professionals who work with offenders believe that treatment proceeds most effectively if the offender is mandated by the courts to participate in a treatment program and if therapeutic progress is closely monitored by the court. Treatment programs for offenders frequently reflect the belief that, like an alcoholic, the child sexual abuse offender has a lifelong problem which requires a constant measure of control. Self help groups, therefore, such as those offerred through Parents United Chapters, are ongoing and encourage the regular, long-term involvement of offenders.

What Can Happen to Families

Childhood sexual abuse and its disclosure are traumas which affect families in ways which are both similar to and different from the effects of other traumatic family events. Other traumatic events include the death of a family member, chronic illness, or divorce of parents. Family members may initially respond with denial, shock, or fear at the onset of the traumatic event. Different families show different degrees of resilience in the face of trauma. A family can quickly learn its strengths and weaknesses as it begins to face the trauma of sexual abuse and its disclosure. The test of the family will be seen in its ability both to provide support and to make the changes necessary to stop the sexual abuse and to protect children from further abuse.

Following the disclosure of sexual abuse, the Department of Social Services interviews the family members to determine the nature and extent of the abuse and to clarify what steps need to be taken to ensure the safety of all children in the home. When the Department substantiates the allegation, short-term protective measures are taken. This often leads to the offender, or, if necessary, the victim, leaving the home. The family in time decides if they would like to reunite. A range of social services and mental health professionals are involved in helping determine if and how the family can safely reunite. Allegations of sexual abuse are also reported to the District Attorney's Office, and some of these complaints are pursued via a criminal investigation and, if indicated, prosecution.

Children are sexually abused by offenders from within their family and from the community at large. Following disclosure of the abuse, the family is likely to be affected by events outside the family and by changes within the family regardless of who the offender is. For example, the Department of Social Services, as well as human services organization personnel, often encourage separation of child and alleged offender. For reasons such as this one, the Department of Social Services and other human services professionals attempt to provide services to the whole family. Some families find the initial DSS involvement helpful and supportive while others may resent the involvement of outside authorities in their family life.

The existence of sexual abuse in a family means that there is a secret in the family. Whether one or many members know about the abuse, it remains a secret until disclosure. Family members who know the secret are likely to demonstrate their pain and discomfort about the abuse in indirect ways. Some might become depressed and even suicidal. Others might abuse drugs or alcohol, do poorly in school, or run away from home. When even a part of the sexual abuse is disclosed, the family members have a chance to address their problems more directly. While initially painful and disorienting, this is the only way that the family can heal itself. Family members who disclose the secrets are giving the family a chance to begin to identify its problems and to decide how to address family issues in a meaningful, helpful way.

The effects of childhood sexual abuse and its disclosure are most strongly felt when the offender is closely involved in the child's life. If the offender is a family member, the effect of the abuse and the trauma of disclosure has, of course, an extremely great impact. The abuse that is initially disclosed is often the 'tip of the iceberg.' The extent of abuse and the severity of the family's problems are often much greater than the initial disclosure would indicate. The disclosure provides an opportunity for the family to receive services and begin to address chronic difficulties. While these problems may focus around the offender or victim, they might also be found in siblings or parents.

When the disclosure is made, family members are often confused, angry, and afraid. Some victims are supported from the start while others are pressured to recant their accusations. Siblings of the victim might be relieved that the secret has been revealed, angry that the family has been disrupted, hurt that so much attention is focused on a brother or sister, or any combination of the above. Often the disclosure of the abuse brings to the fore longstanding family and/or marital problems. Whatever the final outcomes, there is bound to be financial worry and emotional instability for all family members.

There is occasionally publicity following disclosure, or arrest, in a case of child sexual abuse. While this publicity can help other members of the community protect themselves from the offender, it also can deny victims and their families a sense of privacy regarding the abuse. Victims or their siblings might feel embarassed or stigmatized if the abuse becomes a matter of public record. Further court involvement often means that the interviews and publicity will continue. Families are called upon to support their children throughout the process. A gamut of feelings generally accompanies the process, from relief that the child is being protected to increased anxiety and stress due to the many new demands on time and energy. Family members often feel torn between wanting to see an offender prosecuted and wanting to forget that the abuse ever occurred.

Most families are not subjected to court actions and publicity. For those that are, eventually the public exposure fades and the family has the opportunity to return to a more private life. Some parents state positively that they have learned to protect their children more aggressively. Other parents are concerned that they might become excessively fearful and tend to over-protect their children. Family involvement with mental health practitioners can enable parents to negotiate these difficult questions in a way that is most beneficial both to their children and themselves as parents.

Case Histories

The following case histories represent fictional cases, and any similarity to a real case is purely coincidental.

Sally A.

Sally is a four year old who lives with her older brother Jimmy and parents, Mr. and Mrs. A. Her day care provider had noticed that for six weeks she had been preoccupied with going to the bathroom and had complained a number of times that her "pee-pee" hurt. The day care provider asked her if anyone had touched her "pee-pee" in a bad or scary way. Initially Sally would not answer, but eventually she stated that "Johnny" had touched her in a way that hurt and scared her. The day care provider didn't know of a "Johnny" in Sally's life, but wondered if perhaps she had meant to say Jimmy, her brother.

When Sally's mother came to pick her up that day, the provider told her what Sally had said. Mrs. A. was surprised and concerned about Sally. She stated that Johnny was a boy who babysits for many children in the neighborhood. The provider told Mrs. A. that she would notify the Department of Social Services of the allegations.

Following the filing of the 51-A complaint, Mr. and Mrs. A. were contacted by DSS. An appointment was set to interview Sally the following day. During the interview, Sally showed, with the help of anatomically correct dolls, where she had been touched and stated that Johnny, the babysitter, was the offender. The investigator determined that Mr. and Mrs. A. had not been neglectful in allowing Sally to be with Johnny because they had no knowledge of the abuse. The 51-A was substantiated because, although Johnny is a young child himself, he was a babysitter and therefore a caretaker. As a result of the report, the abuse stopped and Sally's parents were able to get her the help she needed.

Johnny B.

Johnny B. is a 12 year old boy who was Sally A.'s babysitter. Following the report that he had sexually abused Sally A., he was interviewed by both DSS and the local police. These interviews established that Johnny had been babysitting for other children whom he may have sexually abused. A further criminal investigation will be held by the police who will, in conjunction with the District Attorney's Office, decide whether to prosecute Johnny.

Johnny is a child himself, and it is important to determine where he learned to be a sexual offender. Johnny lives with his mother and stepfather, Mr. and Mrs. C., and two younger siblings. Johnny told the Department of Social Services investigators that his natural father had been sexually abusing him on weekend visits for the past two years. Future visits were cancelled pending an investigation of the father's home. There is no indication that Mr. and Mrs. C. are sexual offenders. There is suspicion that Johnny may be sexually abusing his two younger siblings. The Department of Social Services asked Mr. and Mrs. C. to place Johnny in his maternal grandmother's home temporarily. This is to ensure that Johnny is not living with any children whom he could potentially abuse. This is seen as a temporary measure until mental health, social service, and law enforcement personnel can better assess what would be necessary to safeguard other children from Johnny. While treatment for Johnny is important, it is crucial that responsible adults recognize that he is an offender and prohibit him from being alone with children younger than himself. It can be anticipated that substantial cooperation will be needed between this family and the professionals involved if Johnny is to remain a part of the family and also be prevented from abusing younger children.

Kathy D.

Kathy is a 10 year old girl living with her parents. She confided in an adult neighbor that her father had been sexually abusing her for one year. She pleaded with the neighbor not to tell anyone or her father would go to jail. The neighbor decided to honor the child's wishes and not betray her confidence. Kathy began to talk to this neighbor more often about the abuse. Eventually the neighbor realized that the child would not stop being hurt until she, as an adult, informed Kathy's mother of the abuse.

Mrs. D. did not initially believe that Kathy had been abused. But after speaking with Kathy and the neighbor for a few hours, she accepted that it was true. Mrs. D. called the Department of Social Services looking for guidance. She was advised to keep her daughter away from her husband until a social worker arrived.

Mrs. D. met with the social worker before her husband arrived home that day. She acknowledged that her marriage had been a difficult one for many years. With the support of the social worker, she decided that her husband should leave the house in order for her daughter to be safe from further abuse. She obtained a restraining order to ensure that Mr. D. could not re-enter the home. When he arrived home that day, the restraining order was served on him by the police, and he left home.

The Department of Social Services felt that it would be extremely traumatic for Kathy to testify. The District Attorney also agreed with family therapists that it was not in the best interests of the child to prosecute.

During the following months, Mrs. D. decided to divorce Mr. D. She was clear that the abuse was not the cause of the divorce but merely the last straw in a troubled marriage. Kathy entered counseling as she and her mother began to face the fact that the abuse had happened, and to build a new home for themselves. Mr. D. was not prosecuted and also chose not to enter therapy. Kathy hopes to be able to visit her father, visits that are supervised by an adult. Social service and mental health professionals work closely together to provide family members with the help they need while ensuring that no further abuse can occur.

Debbie G.

Debbie is a 14 year old girl living with her parents, Mr. and Ms. G., and three younger siblings. She recently told her guidance counselor that her father had been sexually abusing her for five years. The guidance counselor filed a 51-A with the Department of Social Services. Debbie stated to DSS that her mother would not believe her and that she did not want to return home. Ms. G. in fact did not believe Debbie and refused to ask Mr. G. to leave the home. Debbie was placed in foster care pending further assessment of the family.

The other children were interviewed and none of them claimed to have been sexually abused. This allowed Mr. G. to remain in the home despite concerns that he might abuse the other children.

After interviewing Debbie and her father, the District Attorney's Office decided to prosecute Mr. G. Debbie was provided with a Victim/Witness advocate to help her understand and negotiate the court proceedings. Mr. G. was convicted of raping his daughter and sentence to six months in prison. Debbie remains angry at her parents and is not interested in returning to their home. Mr. G. has entered treatment to help control his abusive behaviors and hopes to return to the family home following his release from prison. Ms. G. has received supportive services to help hold the family together while Mr. G. is in prison. She now believes that Mr. G. raped Debbie. Ms. G. is determined to address the family problems and to hold her marriage together.

Barbara K.

Barbara is a 15 year old girl who has run away from home twice in the past year. She has been in therapy for six months to address her difficulties at home and in school. She recently told her therapist that her stepfather had been sexually abusing both her and her younger sister for two years. The therapist filed a 51-A report and also arranged an emergency meeting to tell Barbara's mother, Ms. L. Ms. L. believed the allegations and immediately confronted her husband. Mr. L. admitted that he had been sexually involved with his daughters and agreed to leave home temporarily. Ms. L. obtained a restraining order to ensure that Mr. L. did not return to the home.

The entire family then became involved with social service and mental health professionals. Mr. L. began group therapy with other men who have sexually abused their children. Barbara and her sister meet with individual counselors, as does their mother. This family has decided to try to stay intact while also ending the sexual abuse. The District Attorney's Office has not prosecuted Mr. L. Various professionals and all family members work openly and cooperatively in monitoring and treating the family. The family will not know for many months if they will be able to reunite in a way which precludes any further sexual abuse.

Service Directory for Central Massachusetts

Definitions

Agencies Providing Services by Service
  Services Provided to Victims
  Services Provided to Non-offending Parents
  Services Provided to Offenders
  Services Provided to Adult Survivors of Sexual Abuse
  Services Provided to Others

Agency Service Descriptions
  DSS Area Offices
  OFC Area Offices
  Agencies and Organizations
  Law Enforcement Programs

DEFINITIONS

This Directory presents a listing of all agencies which identified themselves as providers of services in the field of child sexual abuse in their responses to a questionnaire in May, 1986. Inclusion in this directory does not imply endorsement of the agencies and organizations listed here. In addition, because service provision descriptions are based on information taken directly from the questionnaires and despite extensive review for errors and inconsistencies, the Worcester Area Sexual Abuse Task Force does not guarantee that service information is totally complete, or that some programs which were present in May, 1986 are still in existence.

The Directory is organized along two dimensions. The first part is an index of agencies providing services for child sexual abuse arranged by client type and by type of service provided. Client types are: victims, non-offending parents (NOP), offenders, adult survivors of sexual abuse (survivors), and others. The types of service are: crisis intervention, assessment, diagnostic testing, protective services, advocacy, professsionally assisted support and self help groups, prevention and education, individual therapy, and group therapy. The "notes" section also makes mention of couples therapy and/or family therapy when present.

The second part of the Directory is a detailed description of the services provided by each agency or organization. This part is divided into four sub-parts:

(1) Commonwealth of Massachusetts Area Offices
(2) Agencies and Organizations with Special Programs in Child Sexual Abuse
(3) Law Enforcement Agencies and Programs

The following definitions are employed in this Manual:

Crisis Intervention: regular and frequent contact with victims, families, or offenders in the resolution of emergency situations; twenty-four hour hotline is not a requirement of this definition.

Assessment: determination of need for service and type of service; it is not necessary that the determination of need process be formal.

Diagnostic Testing: formal assessment of type and degree of emotional or physical pathology or lack thereof; use of standard instruments and protocols.

Protective Services: actual provision of domiciling or financing for domiciling.

Advocacy: formal representation of client before a court of law, or, formal programs for introducing clients to legal procedures.

Professionally Assisted Support or Self Help Groups: a professional is anyone with an advanced degree in the Human Service or Mental Health Professions; this professional need not be physically present every time the group meets, but a formal reporting procedure between the group and the professional must be involved.

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I. Services Provided to Victims

Crisis Intervention & Assessment

Auburn Project
Boston Road Clinic
CAP of Blackstone Valley
CAP of Worcester
Decision Institute
DSS
Elmwood Counseling Services
Family Center Project
Family Health & SS Center
Family Service Organization
Friendly House
Grt. Brk. Valley Health Center
Hahnemann Hospital
Head Start
Health Awareness Services
Health Information Referral Service
Herbert Lipton Center
Hubbard Human Services Center
Human Resource Institute
Mass. Office for Children
MSPCC
N. Worc. Co. Sex. Abuse Program
N. Worc. Co. Juvenile Probation
Pernet Family Health Agency
Prospect House
Rape Crisis Program
St. Vincent Hospital
Tri-Link
Tri-River Health Center
U. Mass. Medical Center
Valley Adult Counseling Service
Victim/Witness Program
Wells Human Service Center
Worcester Children's Friend Society
Worcester City Hospital
Worcester Youth Guidance Center
Youth Opportunities Upheld

Advocacy

Auburn Project
Boston Road Clinic
CASA Project
DSS
Hahnemann Hospital
Health Information Referral Service
Herbert Lipton Center
Mass. Office for Children
MSPCC
N. Worc. Co. Juvenile Probation
Piedmont Neighb. Opp. Center
Prospect House

Advocacy (cont.)

Rape Crisis Program
Victim/Witness Program
Worcester Co. D.A.'s Office

Diagnostic Testing

Boston Road Clinic
Decision Institute
Family Center Project
Family Health & SS Center
Hahnemann Hospital
Hubbard Human Services Center
Human Resource Institute
N. Worc. Co. Sex. Abuse Program
Prospect House
St. Vincent Hospital
U. Mass. Medical Center
Valley Adult Counseling Center
Wells Human Service Center
Worcester Children's Friend Society
Worcester City Hospital
Worcester Youth Guidance Center
Youth Opportunities Upheld

Protective Services

DSS
MSPCC
Youth Opportunities Upheld

Prevention & Education

Auburn Project
Camp Fire
CAP of Worcester
CAP of Blackstone Valley
DSS
Family Center Project
Family Counseling Collaborative
Family Health & SS Center
Friendly House
Grt. Brk. Valley Health Center
Head Start
Health Awareness Services
Health Information Referral Service
Herbert Lipton Center
Hubbard Human Services Center
MSPCC
N. Worc. Co. Juvenile Probation
N. Worc. Co. Sex. Abuse Program
Pernet Family Health Agency
Prospect House

I. Services Provided to Victims (continued)

Prevention & Education (cont.)

Rape Crisis Program
Worcester City Hospital
Worc. Co. D.A.'s Office
Worcester Girls Club

Individual Therapy

Auburn Project
Boston Road Clinic
Decision Institute
Elmwood Counseling Services
Family Center Project
Family Counseling Collaborative
Family Health & SS Center
Friendly House
Grt. Brk Valley Health Center
Head Start
Health Information Referral Service
Herbert Lipton Center
Hubbard Human Services Center
Human Resource Institute
MSPCC
N. Worc. Co. Sex. Abuse Program
Prospect House
Rape Crisis Program
St. Vincent Hospital
Tri-Link
Valley Adult Counseling Service
Wells Human Service Center
Worcester Children's Friend Society
Worcester City Hospital
Worcester Youth Guidance Center

Group Therapy

Boston Road Clinic
Decision Institute
DSS, Worcester
Family Center Project
Grt. Brk. Valley Health Center
Human Resource Institute
MSPCC
N. Worc. Co. Sex. Abuse Program
Prospect House
Tri-Link
Valley Adult Counseling Service
Worcester Youth Guidance Center

II. Services Provided to Non-Offending Parents

Crisis Intervention & Assessment

Boston Road Clinic
Decision Institute
DSS
Elmwood Counseling Services
Family Center Project
Family Health & SS Center
Grt. Brk. Valley Health Center
Hahnemann Hospital
Health Awareness Services
Health Information Referral Service
Herbert Lipton Center
Hubbard Human Services Center
Human Resource Institute
Mass. Office for Children
MSPCC
N. Worc. Co. Juvenile Probation
N. Worc. Co. Sex. Abuse Program
Pernet Family Health Agency
Prospect House
Psychiatry and the Law Project
Rape Crisis Program
St. Vincent Hospital
Tri-River Health Center
U. Mass. Medical Center
Valley Adult Counseling Service
Victim/Witness Program
Wells Human Service Center
Worcester Children's Friend Society
Worcester City Hospital
Worcester Youth Guidance Center

Advocacy

DSS
Boston Road Clinic
Hahnemann Hospital
Health Information Referral Service
Herbert Lipton Center
Legal Assistance Corporation
Mass. Office for Children
MSPCC
N. Worc. Co. Juvenile Probation
Piedmont Neighb. Opp. Center
Prospect House
Rape Crisis Program
Victim/Witness Program
Worcester Youth Guidance Center

Support & Self Help Groups

Decision Institute
MSPCC
N. Worc. Co. Sex. Abuse Program
Pernet Family Health Agency

Diagnostic Testing

Boston Road Clinic
Decision Institute
Family Center Project
Hahnemann Hospital
Hubbard Human Services Center
Human Resource Institute
N. Worc. Co. Sex. Abuse Program
Psychiatry and the Law Project
St. Vincent Hospital
Valley Adult Counseling Service
Wells Human Service Center
Worcester Youth Guidance Center

Prevention & Education

Camp Fire
DSS
Family Center Project
Family Counseling Collaborative
Grt. Brk. Valley Health Center
Health Awareness Services
Health Information Referral Service
Herbert Lipton Center
N. Worc. Co. Juvenile Probation
N. Worc. Co. Sex. Abuse Program
Pernet Family Health Agency
Prospect House
Rape Crisis Program
Worcester City Hospital

Individual Therapy

Boston Road Clinic
Decision Institute
Elmwood Counseling Services
Family Center Project
Family Counseling Collaborative
Family Health & SS Center
Family Service Organization
Grt. Brk. Valley Health Center
Health Information Referral Service
Herbert Lipton Center
Human Resource Institute
MSPCC
N. Worc. Co. Sex. Abuse Program
Prospect House
Psychiatry and the Law Project
Rape Crisis Program
Valley Adult Counseling Service
Wells Human Service Center
Worcester Children's Friend Society
Worcester City Hospital
Worcester Youth Guidance Center

Group Therapy

Boston Road Clinic
Decision Institute
DSS, Worcester
Family Center Project
Family Counseling Collaborative
Human Resource Institute
MSPCC
N. Worc. Co. Sex. Abuse Program
Prospect House
Psychiatry and the Law Project
Valley Adult Counseling Service

III. Services Provided to Offenders

Crisis Intervention & Assessment

Chandler Street Center
Decision Institute
DSS
Family Center Project
Family Health & SS Center
Grt. Brk. Valley Health Center
Hahnemann Hospital
Herbert Lipton Center
Hubbard Human Services Center
Human Resource Institute
Mass. Office for Children
MSPCC
N. Worc. Co. Sex. Abuse Program
Pernet Family Health Agency
Prospect House
Psychiatry & the Law Project
Rape Crisis Program
Tri-River Health Center
Valley Adult Counseling Service
Worcester Children's Friend Society

Advocacy

DSS
Hahnemann Hospital
Herbert Lipton Center
Piedmont Neighb. Opp. Center
Psychiatry and the Law Project

Diagnostic Testing

Decision Institute
Family Center Project
Family Health & SS Center
Hahnemann Hospital
Hubbard Human Services Center
Human Resource Institute
N. Worc. Co. Sex. Abuse Program
Psychiatry and the Law Project
Valley Adult Counseling Service
Worcester Youth Guidance Center

Support and Self Help Groups

Decision Institute
MSPCC
N. Worc. Co. Sex. Abuse Program

Prevention and Education

DSS
Grt. Brk. Valley Health Center
N. Worc. Co. Sex. Abuse Program
Pernet Family Health Agency
Psychiatry and the Law Project

Individual Therapy

Chandler Street Center
Decision Institute
Family Center Project
Family Health & SS Center
Grt. Brk. Valley Health Center
Herbert Lipton Center
Human Resource Institute
N. Worc. Co. Sex. Abuse Program
Psychiatry and the Law Project
Valley Adult Counseling Service
Worcester Children's Friend Society

Group Therapy

Decision Institute
DSS, Worcester
MSPCC
N. Worc. Co. Sex. Abuse Program
Psychiatry and the Law Project
Valley Adult Counseling Service
Worcester Youth Guidance Center

IV. Services Provided to Adult Survivors of Sexual Abuse

Crisis Intervention & Assessment

Boston Road Clinic
Chandler Street Center
Decision Institute
DSS
Elmwood Counseling Services
Family Counseling Collaborative
Family Health & SS Center
Family Service Organization
Grt. Brk. Valley Health Center
Hahnemann Hospital
Health Awareness Services
Health Information Referral Service
Herbert Lipton Center
Hubbard Human Services Center
Human Resource Institute
Mass. Office for Children
MSPCC
N. Worc. Co. Sex. Abuse Program
Pernet Family Health Agency
Prospect House
Psychiatry and the Law Project
Rape Crisis Program
Tri-River Health Center
Valley Adult Counseling Service
Wells Human Service Center
Worcester Children's Friend Society
Worcester City Hospital
Worcester Youth Guidance Center

Advocacy

Boston Road Clinic
DSS
Hahnemann Hospital
Health Information Referral Service
Herbert Lipton Center
MSPCC
Piedmont Neighb. Opp. Center
Prospect House
Rape Crisis Program

Diagnostic Testing

Boston Road Clinic
Family Health & SS Center
Hahnemann Hospital
Hubbard Human Services Center
Human Resource Institute
N. Worc. Co. Sex. Abuse Program
Psychiatry and the Law Project
Valley Adult Counseling Service
Wells Human Service Center

Support and Self Help Groups

Decision Institute
Family Counseling Collaborative
Family Service Organization
MSPCC
N. Worc. Co. Sex. Abuse Program
Rape Crisis Program

Prevention & Education

Decision Institute
DSS
Family Counseling Collaborative
Grt. Brk. Valley Health Center
Health Awareness Services
Health Information Referral Service
Hubbard Human Services Center
N. Worc. Co. Sex. Abuse Program
Pernet Family Health Agency
Prospect House
Rape Crisis Program

Individual Therapy

Boston Road Clinic
Chandler Street Center
Decision Institute
Elmwood Counseling Services
Family Counseling Collaborative
Family Health & SS Center
Family Service Organization
Grt. Brk. Valley Health Center
Health Information Referrral Service
Herbert Lipton Center
Human Resource Institute
N. Worc. Co. Sex. Abuse Program
Prospect House
Psychiatry and the Law Project
Rape Crisis Program
Valley Adult Counseling Service
Wells Human Service Center
Worcester Children's Friend Society
Worcester City Hospital
Worcester Youth Guidance Center

Group Therapy

Boston Road Clinic
Decision Institute
DSS, Worcester
Family Counseling Collaborative
Human Resource Institute
MSPCC
N. Worc. Co. Sex. Abuse Program
Prospect House
Psychiatry and the Law Project
Valley Adult Counseling Service

V. Services Provided to Others

Crisis Intervention & Assessment

Decision Institute
Family Center Project (Siblings, Non-offending fathers)
Family Health & SS Center
Herbert Lipton Center (Families of active cases)
Human Resource Institute
Massachusetts Office for Children
MSPCC (Non-offending fathers)
Pernet Family Health Agency (Family)
Psychiatry and the Law Project (Adolescents)
Rape Crisis Program (Family, Friends)
Valley Adult Counseling Service
Victim/Witness Program (Family)
Wells Human Service Center (Family)
Worcester Children's Friend Society (Family, Caretakers)

Diagnostic Testing

Decision Institute
Human Resource Institute
Psychiatry and the Law Project (Adolescents)
Valley Adult Counseling Service
Wells Human Service Center (Family)

Advocacy

CASA Project (Court-appointed clients)
Herbert Lipton Center
Legal Assistance Corporation
Mass. Office for Children
Piedmont Neighb. Opp. Center
Rape Crisis Program (Family, Friends)
Victim/Witness Program (Family)

Support & Self Help Groups

MSPCC (Parents of victims abused by a non-family member)

Prevention & Education

Camp Fire (Parents)
CAP of Worcester (Parents, teachers, child care providers)
CAP of Blackstone Valley (Parents, teachers, child care providers)
Family Counseling Collaborative (RNs, EMTs, Social Workers, PTA, Teachers' Organizations)
Head Start (Parents)
Herbert Lipton Center (General community, school systems)
MSPCC (Parents)
Pernet Family Health Agency (Family)
Psychiatry and the Law Project
Rape Crisis Program (Community organizations)
Victim/Witness Program (Police, schools, general public)

Individual Therapy

Auburn Project (Non-family members)
Decision Institute
Family Center Project (Siblings, Non-offending fathers)
Family Counseling Collaborative (Siblings)
Herbert Lipton Center (Families of active cases)
MSPCC (Non-offending fathers)
Rape Crisis Program (Family, Friends)
Psychiatry and the Law Project (Adolescents)
Valley Adult Counseling Service
Wells Human Service Center (Family)
Worcester Children's Friend (Family, Caretakers)
Worcester Youth Guidance Center (Siblings, foster parents)

Group Therapy

Decision Institute
Family Counseling Collaborative (Siblings)
Psychiatry and the Law Project (Adolescents)
Valley Adult Counseling Service

Agency Service Descriptions

Commonwealth of Massachusetts Regional Offices

DEPARTMENT OF SOCIAL SERVICES

Area 10:
Worcester Area Office
340 Main Street, Suite 825
Worcester, Massachusetts 01608
Contact:
Pamela O'Malley
Assistant Area Director
791-1200

For 51-A Contact:
Ed Brank, or Supervisor of Screening Unit
791-1200

Area 6:
Fitchburg Area Office
435 Main Street
Suite 3100
Fitchburg, Massachusetts 01420
Contact:
David Van Kennen
345-2101

Area 7:
Gardner Area Office
196 Main Street
Gardner, Massachusetts 01440
Contact:
Intake Supervisor
632-9104

Area 8:
Blackstone Valley Area Office
185 Church Street
Whitinsville, Massachusetts 01588
Contact:
Gerald E. Nowosacki
Supervisor, Sexual Abuse Team
234-6213

Area 9:
South Central Area Office
P.O. Box 797
Webster, Massachusetts 01570
Contact:
Intake Supervisor
949-0113

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors
Assessment:
Victims, NOP, Offenders, Survivors
Advocacy:
Victims, NOP, Offenders, Survivors
Prevention/Education:
Victims*, NOP*, Offenders*, Survivors*
Law Enforcement:
Victims**
Group Therapy:
Victims***, NOP***, Offenders***, Survivors***

* Area 8 has well developed programs. Area 9 has programs under development.

** SAIN teams have a law enforcement representative as a member of the team. SAIN teams are operating in Areas 6, 8, 9, 10.

*** Area 10 runs a program for adolescent females. Area 7 operates group therapy programs for the four populations above.

OFFICE FOR CHILDREN

Greater Worcester Area Office
75A Grove Street
Worcester, Massachusetts 01605
Contact:
Deborah Dee
Advocate Coordinator
791-3136-7-8

North Central Area Office
435 Main Street
Fitchburg, Massachusetts 01420
Contact:
John Miller
Advocate Coordinator
534-0280/342-8769

Wachusett Area Office
66 Parker Street
Gardner, Massachusetts 01440
Contact:
Donna Moriarty
Advocate Coordinator
632-9179

Blackstone Valley Area Office
One Union Street
Hopedale, Massachusetts 01747
Contact:
Holly Earl
Advocate Coordinator
473-3291

South Central Area Office
112 Hamilton Street
Southbridge, Massachusetts 01550
Contact:
Eileen Perron
Advocate Coordinator
885-5374(direct) 765-9175

Service Summary

Crisis Intervention:	Victims, NOP, Offenders, Survivors, Other
Assessment:	Victims, NOP, Offenders, Survivors, Other
Advocacy:	Victims, NOP

Notes

Crisis information and referral. Advocates assist in obtaining services in special needs, day care, education, foster care, residential placement, mental retardation services, camps, protective services, medical and legal assistance, financial aid, and respite. Support groups for parents are run by Wachusett, South Central, and Worcester. North Central provides family day care services.

Agency Service Descriptions

Agencies
and
Organizations

The Auburn Project, Inc.
63B Auburn Street
Auburn, Massachusetts 01501
Contact:
Therese Dumas
Counselor/Youth Worker
832-5707

Service Summary

Crisis Intervention:
Victims*
Advocacy:
Victims*
Prevention/Education:
Victims*
Individual Therapy:
Victims*, Others**

* Teens only.
** Non-family members.

Notes

The program focuses on substance abuse. Both male and female sexual abuse victims call the agency, however, and are referred to other agencies. The agency provides education sessions for its clients in sexual abuse, and counselors work with sexual abuse clients and go to court with them.

Delivery Characteristics

The agency's programs are totally state-funded and services are free.

Boston Road Clinic
314 Grafton Street
Shrewsbury, Massachusetts 01420
Contact:
Peter Moran PhD
Clinical Director
845-1172

Service Summary

Crisis Intervention:	Victims, NOP, Survivors
Assessment:	Victims, NOP, Survivors
Diagnostic Testing:	Victims, NOP, Survivors
Advocacy:	Victims, NOP, Survivors
Individual Therapy:	Victims, NOP, Survivors
Group Therapy:	Victims*, NOP, Survivors

* Teens only.

Notes

Twenty-four hour 7 day per week coverage. Play therapy for younger children. Groups of up to ten for teens and adults. Individual couples therapy and couples groups. Family therapy.

Delivery Characteristics

Initial evaluation- $71.50; Psychotherapy- $53.50/hour. Reimbursable through BC/BS, Medicaid, and commercial carriers. Limited sliding fee scale tailored to individual cases.

Camp Fire - Central Massachusetts Council
100A June Street
Worcester, Massachusetts 01602
Contact:
Katherine Plainte
Executive Director
753-5398

Service Summary

Prevention/Education:
Victims, Other*
* Parents

Notes

Camp Fire's Children's Awareness Training provides information and skill-building opportunities to children in a variety of situations - Camp Fire clubs, church groups, classrooms. Materials are age-appropriate and may be delivered by trained volunteers as well as professional staff.

Delivery Characteristics

Through membership in the Agency. Fees to community organizations and other agencies vary.

CASA Project
340 Main Street, Suite 817
Worcester, Massachusetts 01608
Contact:
Sue Scrogin
Director
757-9877

Service Summary

Advocacy:
Victims

Notes

The Court Appointed Special Advocate for children 0-18 years is involved in care and protection and divorce/custody issues in juvenile and probate family courts. Volunteers, provided through court appointment only, serve as 'lay' guardian *ad litem* to represent the best interests of the child by investigating and reporting to the court and monitoring services to help ensure permanent place of the child in a timely fashion.

Chandler Street Center, Inc.
105 Merrick Street
Worcester, Massachusetts 01609
Contact:
Sybil A. Goldberg
Executive Director
799-2753

Service Summary

Crisis Intervention:
Offenders, Survivors
Assessment:
Offenders, Survivors
Individual Therapy:
Offenders, Survivors

Notes

Clients have presenting problems of substance abuse. Services for sexual abuse are incorporated into therapy sessions. When sexual abuse is disclosed, other agencies are involved depending on indications. Couples and family therapy are offered.

Delivery Characteristics

Sliding fee scale. Agency sees clients who are unable to pay.

Child Assault Prevention (CAP) Project of Greater Worcester
Quinsigamond Community College
670 West Boylston Street
Worcester, Massachusetts 01606
Contact:
Lory Santoro
Coordinator of Volunteers
853-2300

Service Summary

Crisis Intervention:
Victims*
Prevention/Education:
Victims*, Other**
* Children pre-school through sixth grade.
** Parents, teachers, child care professionals.

Notes

Individualized sessions permit disclosure and initial intervention. Coordination with school personnel. Four components characterize the prevention/education program: (1) Teacher and staff in-service, (2) Parent Program, (3) Children's Workshop, and (4) Individualized Question/Answer Follow-up Sessions. Available for day care centers, pre-schools, elementary schools, and other children's groups.

Delivery Characteristics

Fees vary.

Child Assault Prevention Program of Blackstone Valley (Valley CAP)
23 Dana Park
Hopedale, Massachusetts 01747
Contact:
Peachey Warren
Director
473-0089

Service Summary

Crisis Intervention:
Victims*
Prevention/Education:
Victims*, Others**
* Children pre-school through grade six.
** Parents, teachers, child care personnel.

Notes

Individualized sessions permit disclosure and initial intervention. Coordination with school personnel. The program has four components: (1) Teacher/staff in-service, (2) Parent Program, (3) Children's Workshop, and (4) Individualized Question/Answer Follow-up Sessions. Available for day care centers, pre-schools, elementary schools, and other children's groups.

Delivery Characteristics

Fees vary.

Decision Institute
340 Main Street, Suite 512
Worcester, Massachusetts 01608
Contact:
Josephine Bottone, MSW
Assistant Director
798-2399 & 798-0321

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors, Other
Assessment:
Victims, NOP, Offenders, Survivors, Other
Diagnostic Testing:
Victims, NOP, Offenders, Survivors, Other
Self Help Groups:
Victims, NOP, Offenders, Survivors, Other
Individual Therapy:
Victims, NOP, Offenders, Survivors, Other
Group Therapy:
Victims, NOP, Offenders, Survivors, Other

Notes

Family therapists and sexual abuse specialists work in conjuntion with clinical psychologist and psychiatrist. One week turnaround on diagnostic tests. Twenty-four hour emergency/crisis line. Family groups and couples groups. Family therapy and couples therapy.

Delivery Characteristics

Sliding fee scale. Reimbursable through BC/BS and commercial carriers.

Elmwood Counseling Services
Worcester Area Community Mental Health Center
70 Elm Street
Worcester, Massachusetts 01609
Contact:
Anita Collins, LICSW
Director
791-6062

Stuart Moskowitz, LICSW
Clinical Director
791-6062

Service Summary

Assessment:
Victims*, NOP, Survivors
Individual Therapy:
Victims*, NOP, Survivors
* Adolescents.

Notes

Couples therapy and family therapy available.

Delivery Characteristics

Sliding fee scale. Reimbursable by BC/BS, Medicare, Medicaid, CMHC, and commercial carriers.

Family Center Project - U. Mass. Medical Center
55 Lake Avenue North
Worcester, Massachusetts 01605
Contact:
Joanne Nicholson, PhD
Coordinator, Sexual Abuse Treatment Program
856-3163

Mark Horwitz, MSW
Clinical Social Worker, Mothers Therapy Group
856-3163

Service Summary

Crisis Intervention:
Victims, NOP
Assessment:
Victims, NOP, Offenders, Other**
Diagnostic Testing:
Victims, NOP, Offenders
Prevention/Education:
Victims, NOP
Individual Therapy:
Victims, NOP, Offenders, Other**
Group Therapy:
Victims*, NOP

* Group therapy for 7-11 year old girls being developed(6/86)
** Assessment and Therapy for siblings and non-offending fathers.

Notes

Crisis intervention as needed both,in initial intervention with new families and on-going. Three types of assessment: (1) as part of initial assessment sometimes with Worcester DSS usually including younger children, (2) long term assessment of parental fitness, (3) assessments to determine treatment needs. Full range of psychological testing and medical team whose members provide therapeutic physical exams to substantiate abuse. Prevention and education on individual basis to individuals in treatment.

Delivery Characteristics

DSS closed referral system. Available only to families on treatment contract except for medical therapeutic physical exams which are open referral.

Family Counseling Collaborative
22 Summer Street
Westborough, Massachusetts 02172
Contact:
Lois J. Barry, RN
Program Director
366-4707

Service Summary

Crisis Intervention:
    Survivors
Assessment:
    Survivors
Self Help Groups:
    Survivors
Prevention/Education:
    Victims, NOP, Survivors, Other*
Individual Therapy:
    Victims, NOP, Survivors, Other**
Group Therapy:
    NOP, Survivors, Other**

* RNs, EMTs, social workers, PTA, teacher's organizations.
** Conjoint sibling therapy.

Notes

Twenty-four hour on call service for adult survivors. Support groups- ongoing open-ended model, 12 week closed model. Family systems approach in individual and couples and family therapy. Group therapy for both male and female adult survivors.

Delivery Characteristics

BC/BS reimbursable. Otherwise sliding scale fees- individual $20-75, group $20-35.

Family Health and Social Service Center
875 Main Street
Worcester, Massachusetts 01610
Contact:
Jeanne Wess LICSW
Director of Social Work Service
756-3528

Service Summary

Crisis Intervention:
    Victims, NOP, Offenders, Survivors, Other
Assessment:
    Victims, NOP, Offenders, Survivors, Other
Diagnostic Testing:
    Victims*, Offenders, Survivors
Prevention/Education:
    Victims**
Individual Therapy:
    Victims, NOP, Offenders, Survivors

* Not done for children under 15 years.
** 9-12 years.

Notes

Physicians and social workers commonly perform combined evaluations and assessments. Currently a prevention program at Woodlawn School; four schools to start 9/86. When physicians perform well-child exams they speak to the children about sexual abuse. Individual therapy focuses on play therapy for children 4-12. Few offenders are seen for treatment and large numbers of adult survivors are seen. Therapy for couples or families is available when indicated.

Delivery Characteristics

Sliding fee scale according to family income and number in family, range $5.00 to $22.50. Reimbursable in to all insurance carriers and Medicaid, AFDC and SSI categories. CMHC agency provider. Jobs Bill Funds. MA requires prior approval after 26 sessions. Other carriers have $500 limit (10 sessions) after which clients are placed on sliding fee scale. Usually about 1 week waiting time.

Family Service Organization of Worcester, Inc.
31 Harvard Street
Worcester, Massachusetts 01609
Contact:
Admissions Therapist
756-4646

Service Summary

Crisis Intervention:
Victims*, Survivors
Assessment:
Victims*, Survivors
Self Help Groups:
Survivors**
Individual Therapy:
NOP, Survivors
* Older Teens. Younger children most commonly referred.
** Will start a group 9/12/86.

Notes

Adults presenting with acute recall of sexual abuse are seen one or two times a week. They often stay in treatment long term after the initial crisis and are seen weekly. Therapy groups do not focus on sexual trauma (except the one planned mentioned above). Couples therapy available conjointly with individual therapy.

Delivery Characteristics

Sliding fee scale- $5-50. Reimbursable through BC/BS, CMHC, and commercial carriers.

Friendly House Multiservice Center
36 Wall Street
Worcester, Massachusetts 01604
Contact:
William Terrill
Director, Specialized Child Care Unit
755-4362

Service Summary

Crisis Intervention:
Victims*
Assessment:
Victims*
Prevention/Education:
Victims*
Individual Therapy:
Victims*
* 7-14 years.

Notes

The program recreational in nature, and works closely with schools, other agencies, and families in case management and continuity issues. Assessment with consulting psychologist every 3-6 months.

Delivery Characteristics

Services provided through contract with DSS. No fees.

Great Brook Valley Health Center
32 Great Brook Valley Avenue
Worcester, Massachusetts 01605
Contact:
Joe Cambray, Mental Health Department Head, Victims, NOP
852-1805

P. Caswell
Staff Psychologist, Teens, Offenders
852-1805

J. Kraft, LICSW
Clinical Director, Survivors
852-1805

Service Summary

Crisis Intervention:
Victims*, NOP, Offenders, Survivors
Assessment:
Victims*, NOP, Offenders, Survivors
Prevention/Education:
Victims*, NOP, Offenders, Survivors
Individual Therapy:
Victims*, NOP, Offenders, Survivors
Group Therapy:
Victims*

* Primarily 0-12 years. Staff psychologist works with teens.

Notes

Location facilitates outreach to home and school. Bilingual advocacy capability. Staff psychologist works with teenagers on an as-needed basis.

Delivery Characteristics

Sliding scale of fees from $2.50 per half hour (counseling) and $0 per hour (consultation). BC/BS and Medicaid reimbursable.

Hahnemann Hospital Social Service
281 Lincoln Street
Worcester, Massachusetts 01605
Contact:
Cindy B. Furhman, LICSW
792-8145

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors
Diagnostic Testing:
Victims, NOP, Offenders, Survivors
Advocacy:
Victims, NOP, Offenders, Survivors

Notes

Crisis intervention includes short term counseling and referral. Medical diagnostics only.

Delivery Characteristics

No fees for social service interventions. Reimbursable through BC/BS, Medicaid, and private carriers.

Head Start - Child Development
280 May Street
Worcester, Massachusetts 01602
Contact:
Rosemary Deedy
Supervisor, Social Service
799-3225

Service Summary

Crisis Intervention:
Victims*
Assessment:
Victims*
Prevention/Education:
Victims*, Other**
* 3-4 year-olds.
** Parents

Notes

Child Assault Prevention Program was presented to all Head Start enrollees and parents by trained staff members. Individual therapy provided by agency social workers working with DSS staff.

Delivery Characteristics

Publicly funded program. No fees.

Health Awareness Services of Central Massachusetts, Inc.
71 Elm Street
Worcester, Massachusetts 01609
Contact:
Frances Anthes
Director, ACCESS
756-7123

Service Summary

Crisis Intervention:
Victims, NOP, Survivors
Assessment:
Victims, NOP, Survivors
Prevention/Education:
Victims, NOP, Survivors

Notes

Services are provided through three modes: (1) ACCESS program for pregnant and parenting teenagers and their families, (2) health education programs of the Adolescent Health Care Program, and (3) family planning clinics and adolescent health clinics. Clients receive services through groups and individually.

Delivery Characteristics

No fees for children 12 and under and for teens in ACCESS and Adolescent Health Care Program. Sliding fee scale for family planning services.

Health Information Referral Service
169 Pleasant Street
Marlboro, Massachusetts 01752
Contact:
Bettina Wingate, LICSW
Executive Director
481-8290

Elaine Payne, LICSW
Coordinator, Teen Health
481-8290

Bonnie Horka
Coordinator, Child Assault Prevention Program
481-8290

Diane Rigney
Coordinator, Rape Hotline
481-8290

Service Summary

Crisis Intervention:
    Victims, NOP, Survivors
Assessment:
    Victims, NOP, Survivors
Advocacy:
    Victims, NOP, Survivors
Prevention/Education:
    Victims, NOP, Survivors
Individual Therapy:
    Victims, NOP, Survivors

Notes

Rape Hotline, 24 hour. CAP program inlcuding parent, teacher, and classroom workshops. Group for rape victims beginning Fall, 1986. Family therapy with children and non-offending parent.

Delivery Characteristics

Sliding scale fee ($1.00 - $40.00). Reimbursable through BC/BS and private carriers.

Herbert Lipton Community Mental Health Center
ACCESS Program
45 Pearl Street
Leominster, Massachusetts 01453
Contact:
Carolyn Droser, LICSW
Director
537-6039

Service Summary

Crisis Intervention:
Victims*, NOP*, Offenders*, Survivors*, Other**
Assessment:
Victims, NOP, Offenders, Survivors, Other**
Advocacy:
Victims, NOP, Offenders, Survivors, Other
Prevention/Education:
Victims, NOP, Other***
Individual Therapy:
Victims, NOP, Offenders, Survivors****, Other**

* Provided to active cases.
** Provided to families of active cases, e.g. fathers, sibs, etc.
*** General community, school systems.
**** As part of cases with current sexual abuse of child.

Notes

All families are referred to the ACCESS program by the Department of Social Services. Crisis intervention is provided to referred families. Formal four week family assessment. Some diagnostic testing on a limited basis through the Mental Health Center. Women's and other support groups are run as needed. Special program for training primary prevention to teachers in daycare centers and elementary schools in Worcester County. Group therapy is provided as needed when there are sufficient numbers of client referrals. Couples, siblings, and family therapy provided when appropriate. Couples groups provided for parenting and primary prevention only. ACCESS has a specialized Sexual Abuse Treatment Team composed of ACCESS staff, and clinicians treating cases of sexual abuse in the four outpatient clinics of the center. An ACCESS staff member serves as consultant to the Fitchburg DSS Sexual Abuse Intervention (SAIN) Team.

Delivery Characteristics

Fees are established only for cases in which families have no insurance. Fees of $1-10 are based on client income and are mutually agreed upon by the client and the clinician. No family is refused service because of inability to pay. Reimbursable through BC/BS, Medicaid, and commercial carriers. Due to DSS-DMH funding, the agency does not have limits on the number of client contracts, nor does treatment require adjusting when insurance expires.

Hubbard Human Services Center
Thompson Road
Webster, Massachusetts 01570
Contact:
Michael Gareau, PhD
Clinical Director
943-2600, ext. 272

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors
Assessment:
Victims
Diagnostic Testing:
Victims, NOP, Offenders, Survivors
Prevention/Education:
Victims
Individual Therapy:
Victims

Notes

Twenty-four hour emergency service psychiatric coverage. Physical and psychosocial assessments. Individual psychotherapy for victims of all ages.

Delivery Characteristics

Sliding fee scale. Reimbursable by most third party payors.

Human Resource Institute
340 Main Street, Suite 512
Worcester, Massachusetts 01608
Contact:
Josephine Bottone
Assistant Director
798-2399 & 798-0321

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors, Other
Assessment:
Victims, NOP, Offenders, Survivors, Other
Diagnostic Testing:
Victims, NOP, Offenders, Survivors, Other
Individual Therapy:
Victims, NOP, Offenders, Survivors, Other
Group Therapy:
Victims*, NOP, Survivors

* Teens.

Notes

Family therapists and sexual abuse specialists work with clinical psychologist and psychiatrist. One week turnaround on diagnostic tests. Family and couples groups. Family and couples therapy.

Delivery Characteristics

Sliding fee scale. Reimbursable through BC/BS and Medicaid. Clients are not terminated because of expiration of insurance.

Legal Assistance Corporation of Central Massachusetts
332 Main Street, Suite 320
Worcester, Massachusetts 01608
752-3718

Service Summary

Advocacy:
NOP, Other

Notes

The agency represents the non-offending parent in civil proceedings either to seek custody of the victimized child or to prevent the offending parent from visiting with the child. Agency services are available only to low income individuals who are at approximately 125% Federal Poverty Level. The agency will represent the non-offending parent of any aged child. The agency does not represent individuals in any criminal proceedings.

Massachusetts Society for the Prevention of Cruelty to Children
286 Lincoln Street
Worcester, Massachusetts 0160
Contact:
Jack Hagenbuch, LICSW
Assistant Regional Director
753-2967 & 1-800-442-3035

Patricia Moran, LICSW
Supervisor, Sexual Abuse Treatment Program
753-2967 & 1-800-442-3035

Patricia Litchfield, M.Ed.
Community Education
753-2967 & 1-800-442-3035

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Other*
Assessment:
Victims, NOP, Offenders**, Survivors**
Advocacy:
Victims, NOP, Survivors
Self Help Groups:
NOP, Offenders, Survivors, Other***
Prevention/Education:
Victims, Others****
Individual Therapy:
Victims%, NOP, Other*
Group Therapy:
Victims%%, NOP, Offenders, Survivors

* Non-offending fathers.
** For group purposes only.
*** For parents of victims abused by a non-family member.
**** Parent groups, general community, schools, child care professionals.
% 6-18 years.
%% Teens.

Notes

Special sexual abuse treatment team is located in Framingham, and services Region II clients who travel there. If MSPCC cannot respond to a crisis within 24-48 hours, the client is referred to an agency that can. Assessment made of client and family. All self-help groups and group therapy programs are part of Parents United. Many prevention programs included an agency produced film "Some Secrets Are For Telling."

Delivery Characteristics

No fees are charged directly to clients. Prevention services for all populations are also covered.

Pernet Family Health Agency
237 Millbury Street
Worcester, Massachusetts 01602
Contact:
Elizabeth Reidy, LICSW
Personnel & Program Consultant
755-1228

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors
Assessment:
Victims, NOP, Offenders, Survivors, Other*
Self Help Groups:
NOP
Prevention/Education:
Victims, NOP, Offenders, Survivors, Other*

* Primarily other family members.

Notes

Nurse and family worker perform crisis intervention and family assessment in the home. Health team reviews assessments to develop treatment plan, advocacy and referral to other agencies. Mothers group and couples facilitation as well as prevention/education activities for mothers, fathers, preschoolers, and adolescents are provided by LICSW.

Delivery Characteristics

Agency programs are funded by contracts with DSS and Health Services are funded by DPH. Group services as well as in home services are included in these contracts and there are no special fees.

North Worcester County Sexual Abuse Treatment Program
196 Main Street
Gardner, Massachusetts 01440
Contact:
Judy Linkous, Coordinator
632-9104 & 632-9400

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors
Assessment:
Victims, NOP, Offenders, Survivors
Diagnostic Testing:
Victims*, NOP, Offenders, Survivors
Self Help Groups:
Victims*, NOP, Offenders, Survivors
Prevention/Education:
Victims, NOP, Offenders, Survivors
Individual Therapy:
Victims*, NOP, Offenders, Survivors
Group Therapy:
Victims, NOP, Offenders, Survivors
* For 6-18 years only.

Notes

The Agency is a chapter of Parents United. Self help groups are twice monthly voluntary meetings of Parents United; participants must be involved in group therapy. Groups include those for non-offending mothers, female victims (separate groups for ages 4-6 (play therapy), 7-12, and 13-18), adolescent male perpetrator/victim group- ages 12-16, and male adult perpetrators group- over 17 years. Prevention/education workshops and consultations to schools and community agencies. Couples and family therapy available as needed. In addition, there is a voluntary group composed of mothers, adolescent victims and perpetrators which is run by the members with professionals as sponsors. Members of the group are being trained for community education, support to other families, and legal advocacy.

Delivery Characteristics

Sliding fee scale. Clients not rejected because of financial status.

Prospect House, Inc.
129 Lincoln Street
Worcester, Massachusetts 01605
Contact:
Liz Salmon
Deputy Director, Family & Childrens Services: Victims
752-8586

Ann Jachola
Coordinator, Sharing our Survival: Adults
752-8586

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors
Assessment:
Victims, NOP, Survivors
Diagnostic Testing:
Victims*
Advocacy:
Victims, NOP, Survivors
Prevention/Education:
Victims, NOP, Survivors
Individual Therapy:
Victims*, NOP, Survivors
Group Therapy:
Victims*, NOP, Survivors
* Teens.

Notes

All services are provided through three age appropriate groups: (1) Prospect House Family Day Care Program, (2) Emergency Adolescent Services Program, and (3) Sharing Our Survival Program. Diagnostic testing is provided to adolescents through the Emergency Adolescent Services. Individual and group therapy provided to clients in Foster Care, Emergency Adolescent Services, and Sharing our Survival.

Delivery Characteristics

Family Day Care sliding scale fee for day care only. No fee for others programs or services. DSS contracts are held in the three programs. No other reimbursement. Open referral on Family Day Care and Sharing our Survival; closed on Foster Care and Emergency Adolescent Services.

Piedmont Neighborhood Opportunity Center, Inc.
41 Piedmont Street
Worcester, Massachusetts 01610
Contact:
Cheri Valentin
Executive Director
754-7274

Service Summary

Advocacy:

Victims, NOP, Offenders, Survivors, Other

Notes

Legal advocacy provided to neighborhood residents.

Delivery Characteristics

Publicly funded. Services provided free.

Psychiatry and the Law Project
Worcester Area Community Mental Health Center
72 Jacques Avenue
Worcester, Masssachusetts 01609
Contact:
Carlton Watson, LICSW
Director
756-4354

Service Summary

Assessment:
    NOP, Offenders, Survivors, Other*
Diagnostic Testing:
    NOP, Offenders, Survivors, Other*
Prevention/Education:
    Offenders
Individual Therapy:
    NOP, Offenders, Survivors, Other*
Group Therapy:
    NOP, Offenders, Survivors, Other*
* 15-21 year olds.

Notes

Interventions stress multi-technique assessments and therapies. Treatment may be extended to include family and significant others.

Delivery Characteristics

Sliding fee scale with costs averaging $5-10 per session (individual and group) and $10-20 per session for couples therapy. Reimbursable through BC/BS and Medicaid.

Rape Crisis Program of Worcester, Inc.
1016 Main Street
Worcester, Massachusetts 01603
Contact:
Marianne Winters
Assoc. Director for Direct Service
791-9546

HOTLINE: 799-5700

Service Summary

Crisis Intervention:
Victims*, NOP, Offenders, Survivors, Other**
Assessment:
Victims*, NOP, Survivors, Other**
Advocacy:
Victims, NOP, Survivors, Other**
Self Help Groups:
Survivors
Prevention/Education:
Victims*, NOP, Survivors, Other***
Individual Therapy:
Victims, NOP, Survivors, Other**

* Teens, 14-18 years.
** Other Family Members and Friends.
*** Community Groups.

Notes

Twenty-four hour hotline available. Assessment to determine appropriate referrals. Escort individuals and families to hospitals, police, or courts and describe systems to them. Self help groups and therapy groups as staff time permits.

Delivery Characteristics

All services are provided free of charge.

Tri-Link, Inc.
51 Everett Street
Southbridge, Massachusetts 01550
Contact:
Karl Gustafson, LICSW
Coordinator of Clinical Services
765-9101

Service Summary

Crisis Intervention:
Victims*
Assessment:
Victims*
Individual Therapy:
Victims*
Group Therapy:
Victims*
* Teenagers only.

Notes

As a general family service agency, Tri-Link does not have ongoing specialized programs in victim or offender treatment. In the absence of specialized treatment, however, we do work with victims, and sometimes teenage offenders, if the issue rises in the course of more general treatment or if intake screening reveals sexual abuse. We have recently run a closed group for adolescent victims. Teenagers in the area in need of a group should contact us in the event we decide to run the group again. The agency has 24 hour counselor availability by answering service. General psychosocial assessments are provided and weekly individual meetings with clients are arranged.

Delivery Characteristics

Reimbursement primarily through insurance carriers except for Medicaid and CMHC. After insurance expires, fee for service with a sliding scale to clients from those towns which financially support Tri-Link.

Saint Vincent Hospital
25 Winthrop Street
Worcester, Massachusetts 01604
Contact:
Sean Palfrey, MD
Chief of Pediatrics
798-6241

Deborah Lebeaux, MSW
Pediatric Social Service
798-6101

Service Summary

Crisis Intervention:
Victims, NOP
Assessment:
Victims, NOP
Diagnostic Testing:
Victims, NOP
Individual Therapy:
Victims

Notes

Social service intervention is available at the service site in the hospital (emergency room, outpatient clinic, inpatient services) for patients who have been abused. Crisis intervention consists of support for the victim and family, decisionmaking and planning, and information and referral. Social Service also provides advocacy services in acting as family support and liaison between community agencies and the family until those agencies take over primary care. The medical staff provides performs physical assessments and therapy. Social Service interviews the child to provide assessment in terms of the emotional trauma experienced by the child. Such assessment is available through the Outpatient Pediatric Clinic. Diagnostic testing is available through the Pediatric Neurodevelopmental Clinic.

Delivery Characteristics

Sliding fee scale for outpatient visits. No special fees. BC/BS and Medicaid reimbursable.

Tri-River Health Center
East Hartford Avenue
Uxbridge, Massachusetts 01569
Contact:
David Tapscott, MD
Child Victims
278-5573

Charles Sweet, MD
Adults
278-5573

Service Summary

Crisis Intervention:
Victims, NOP, Offenders, Survivors
Assessment:
Victims, NOP, Offenders, Survivors

Notes

Medical facility. Individual crisis counseling by MD. Referral for long term counseling.

Delivery Characteristics

Sliding fees. Reimbursable through BC/BS and Medicaid.

University of Massachusetts Medical Center
Department of Pediatrics
55 Lake Avenue North
Worcester, Massachusetts 01605
Contact:
Deborah Lynn, MSW
856-3403

Deborah Madansky, MD
856-2853

EMERGENCY: 856-3511

Service Summary

Crisis Intervention:
Victims, NOP
Assessment:
Victims
Diagnostic Testing:
Victims

Notes

All three types of service take place in the context of a pediatric examination with support from a social worker. Services take place in the Emergency Room (recommended for assault less than 72 hours prior to the examination) or, on a limited basis, in the Sexual Abuse Clinic or Adolescent Clinic, both staffed by multidisciplinary, bilingual teams. Physical examinations and cultures for STD.

Delivery Characteristics

ER- $136-227; Sexual Abuse Clinic- $102; Adolescent Clinic- $112. Reimbursable to most third party payors. Most cases resolved in 1-2 visits. If third party payment not available, payment may be waived.

Valley Adult Counseling Service, Inc.
115 Water Street
Milford, Massachusetts 01757
Contact:
Ira Schor, LICSW
Director of Outpatient Services
478-0820 & 839-6921

Steven I. Lessin, PhD
Director of Clinical Services
478-0820 & 839-6921

Bellingham Clinic: 966-1100; 883-1308

Service Summary

Crisis Intervention:
Victims*, NOP, Offenders, Survivors, Other**
Assessment:
Victims*, NOP, Offenders, Survivors, Other**
Diagnostic Testing:
Victims*, NOP, Offenders, Survivors, Other**
Individual Therapy:
Victims*, NOP, Offenders, Survivors, Other**
Group Therapy:
Victims*, NOP, Offenders, Survivors***, Other**

* 18 years.
** Any person 18 years or older.
*** Survivors group under development for Fall 1986.

Notes

Crisis intervention available 9-5 Monday through Friday. If it is known that client needs hospitalization Milford/Whitinsville Hospital should be contacted directly. Intellectual, achievement, and personality testing. Individual psychotherapy and group therapy of 4-8 clients. Couples therapy and family therapy. Community Support Program offers a variety of day-long programming.

Delivery Characteristics

Sliding fee scale starting at $0. Reimbursable through BC/BS, Medicaid, and commercial carriers. Services not denied due to inability to pay.

Victim/Witness Assistance Program
Worcester County District Attorney's Office
332 Main Street
Worcester, Massachusetts 01608
Contact:
Anthony J. Pellegrini
Program Director
757-2786

Service Summary

Crisis Intervention:
Victims, NOP, Other*
Advocacy:
Victims, NOP, Other*
Prevention/Education:
Other**
* Any other family member.
** Police, school and the general public.

Notes

The agency provides support and information to victims, their parents, and other family members from initial disclosure/arrest throughout the entire criminal justice process. Contact by clients is often made immediately after disclosure or arrest. Most commonly covered prevention topics are the dynamics of child sexual abuse, the D.A.s reporting bill, and the rights of sexual abuse victims.

Delivery Characteristics

There are no fees for services.

Wells Human Service Center
29 Pine Street
Southbridge, Massachusetts 01550
Contact:
Barbara Prince, PhD
765-9167

For Crisis Intervention:
Sandra Eagles, MEd,
Coordinator, Harrington Memorial Hospital ER Dept.
765-9771

Service Summary

Crisis Intervention:
Victims*, NOP*, Other*
Assessment:
Victims, NOP, Survivors, Other**
Diagnostic Testing:
Victims, NOP, Survivors, Other**
Individual Therapy:
Victims, NOP, Survivors, Other**

* Crisis intervention in performed through Psychiatric Emergency Services at Harrington Memorial Hospital.

** Other family members.

Notes

Family therapy is provided when indicated.

Delivery Characteristics

Sliding fee scale. Reimbursable through most third party payors.

Worcester Children's Friend Society
21 Cedar Street
Worcester Massachusetts 01609
Contact:
Intake Worker
753-5425

Service Summary

Assessment:
Victims, NOP*, Offenders*, Survivors*, Other*
Diagnostic Testing:
Victims
Individual Therapy:
Victims, NOP*, Offenders*, Survivors*, Other*

* Services offered to parents, other adult caretakers, and other family members in the context of provision of services to the referred child.

Notes

Worcester Children's Friend Society is a licensed, free-standing mental health clinic. An intake worker conducts initial interviews with child and family and then meets with the assessment team to formulate diagnostic plan. Diagnostic testing includes intellectual evaluations and projective/ personality testing. A specialist in therapeutic education performs psychoeducational testing when the client is having school problems. Couples and family therapy is offered when diagnostically indicated.

Delivery Characteristics

Basic fee is $80 per hour. For those unable to pay, there is a sliding fee scale starting at $1 per hour. Reimbursable through BC/BS, Medicaid, CMHC, and other private carriers. When third party payment expires, a fee is set in consultation with the client based on ability to pay.

Worcester City Hospital
26 Queen Street
Worcester, Massachusetts 01610
Contact:
Rosanna Swillo, LICSW
Director of Social Services
799-8381

Robert W. Sorrenti, MD
Chief of Pediatrics
799-8381

Service Summary

Crisis Intervention:
Victims, NOP, Survivors*
Assessment:
Victims, NOP, Survivors*
Diagnostic Testing:
Victims**
Prevention/Education:
Victims, NOP
Individual Therapy:
Victims***, NOP***, Survivors***
* Occasionally.
** Medical diagnostic testing only.
*** Limited and short term.

Notes

Sexual Abuse Team which encounters many first disclosures. When indicated sheltering is provided in Pediatric Unit. Pediatric social worker provides service integration and advocacy services and performs psycho-social assessments which complement medical assessment. Prevention/education activities in conjunction with MSPCC. Some short term individual therapy through Pediatric Clinic/Adolescent Clinic.

Delivery Characteristics

The Agency accepts all third party payors. No patient is denied service because of inability to pay.

Worcester Girls Club
125 Providence Street
Worcester, Massachusetts 01604
Contact:
M. Frances Conlin
Executive Director
755-6455

Service Summary

Prevention/Education:
Victims*

* Seventy-nine percent of the membership is under age 12.

Notes

The Agency is a membership organization drawing from the public, parochial, and private schools in and around Worcester. Opportunities for participatory recreation and skill development are provided in activities at Lincoln House, Winthrop House, and Camp Kinneywood. The Agency has a program entitled "Kid Ability" which was developed by the Girls Club of Omaha in 1978. Three components of the program are information for parents and educators, training for adult program volunteers, and training for children, ages 6-12.

Delivery Characteristics

Through membership in the agency and/or payment of camp fees.

Worcester Youth Guidance Center
275 Belmont Street
Worcester, Massachusetts 01604
Contact:
Susan V. Quinby
Coordinator, Sexual Abuse Treatment Team
791-3261

Service Summary

Crisis Intervention:
Victims, NOP, Survivors
Assessment:
Victims, NOP
Diagnostic Testing:
Victims, NOP*, Offenders*
Individual Therapy:
Victims, NOP, Survivors, Other**
Group Therapy:
Victims***, Offenders****

* Closed referral.
** Siblings, foster parents.
*** 6-18 year olds.
**** Under 18 years only.

Notes

Phone availabilty (no direct service) 24 hours a day. Couples therapy and family therapy available if there is a child victim.

Delivery Characteristics

Sliding scale with no one denied services because of inability to pay. Remibursable through BC/BS, Medicaid, and commercial carriers. About 100 clients seen annually.

Youth Opportunities Upheld, Inc.
"The Village"
979 Millbury Street
Worcester, Massachusetts 01607
Contact:
Paul F. Kelleher, LICSW
Director, Emergency Shelter Programs
757-5579

Service Summary

Crisis Intervention:
Victims*
Assessment:
Victims*
Diagnostic Testing:
Victims*
* Teenagers.

Notes

Emergency shelter for all teens in need of service. Twenty-four hour phone line and supervision for one to one crisis intervention counseling. Initial assessment interview, case conferencing and history taking with families. Individual and group counseling and enrollment in in-house school.

Agency Service Descriptions

Law Enforcement Programs

Northern Worcester Juvenile Probation Department
100 Elm Street
Fitchburg, Massachusetts 01420
Contact:
Mary T. Gibbons
Chief Probation Officer
345-2111

Service Summary

Crisis Intervention:
 Victims, NOP
Assessment:
 Victims
Advocacy:
 Victims, NOP
Prevention/Education:
 Victims, NOP

Notes

Cases are screened for Clerk/Magistrate and referred to Court, Agency, D.A., or Police. Bulletin board information is provided.

Delivery Characteristics

There are no fees for services.

Worcester County District Attorney's Office
Child Abuse Unit
332 Main Street, Fourth Floor
Worcester, Massachusetts 01608
Contact:
Michael E. Donnelly
Assistant District Attorney
Child Abuse Unit Director
755-2786 or 755-8601

Service Summary

Advocacy:
- Victims

Prevention/Education:
- Victims

Notes

In cooperation with with Areas I, II, IV, or the Department of Social Services, which are all or in part within agency jurisdiction, the agency works to coordinate child abuse investigations. In cooperation with DSS, the Crime Prevention and Control Unit of the Massachusetts State Police, and other police departments the office participates in the operation of three special interdisciplinary videotaping teams geared to quick response to abused children. Also work with local schools, police departments, and human services agencies in providing information on child abuse and the laws concerning its reporting and prosecution.

Delivery Characteristics

There are no fees for services.

Reference Material

Massachusetts Statutes Relating to Child Sexual Abuse

The Medical Examination

Resource Materials

Request Form for Comments and Suggestions

Request Form for Agency Information

Request Form for Training

Massachusetts Statutes Relating To Child Sexual Abuse

INTRODUCTION

In the past few years a range of legislation concerning child sexual abuse has come into effect in the Commonwealth of Massachusetts.

Before 1983 there was no requirement for the Department of Social Services to report to the District Attorney's Office any abuse of children other than the death of a child. Since 1983 hundreds of cases have been referred by the Department of Social Services to District Attorney's Offices throughout the Commonwealth. Victims, including victims in child sexual abuse, now have the right to be heard by a judge before the judge imposes a sentence on a defendant. A new law now provides for in-court videotaping of child victims. Seen as a pattern, this group of laws represents a positive step toward better solutions for child sexual abuse matters, while balancing the rights of the accused.

This group of laws should be seen as one step but not a final step in this area. The reference material below is presented to give the reader an overview of current legislation and a suggestion of future legislative directions. At the core of this future legislation will probably be the striking of a balance between the rights of the child victim and the rights of the defendant. Aggressive advocacy on both sides of the debate, tempered with patience and concern for opposing points of view, can ensure the best legislation in the years ahead.

Index of Statutes Presented Below:

1. Injured Children/ The Reporting Law: 51A.
2. Physically or emotionally injured children; duties of department: 51B
3. Videotaping Law.
4. Indecent Assault and Battery on Child under Fourteen.
5. Rape and Abuse of Child.
6. Rape of Child: Use of Force.
7. Application for a 209A Petition for Protection from Abuse.
8. Remedies/"The 209A Law."
9. Confidential Information/Disclosure.
10. Competency/Makhanoff v. Truehart.
11. Amendments: 51-A Law.

PHYSICALLY OR EMOTIONALLY INJURED CHILDREN

Caption editorially supplied

Law Review Commentaries

Law of patient care. Michael Broad (1983) 68 Mass.L.Rev. 10.

Rights of child witnesses. Jacqueline Y. Parker (1981-1982) 17 New England L.Rev. 643.

United States Supreme Court

Child abuse proceedings, federal court abstention, see Moore v. Sims, 1979, 99 S.Ct. 2371, 442 U.S. 415, 60 L.Ed.2d 994.

§ 51A. Injured children, reports; immunity; privileged communications; penalties; notice of determination

Any physician, medical intern, hospital personnel engaged in the examination, care or treatment of persons, medical examiner, psychologist, emergency medical technician, dentist, nurse, chiropractor, podiatrist, osteopath, public or private school teacher, educational administrator, guidance or family counselor, day care worker, probation officer, clerk/magistrate of the district courts, social worker, foster parent, firefighter or policeman, who, in his professional capacity shall have reasonable cause to believe that a child under the age of eighteen years is suffering serious physical or emotional injury resulting from abuse inflicted upon him including sexual abuse, or from neglect, including malnutrition, or who is determined to be physically dependent upon an addictive drug at birth, shall immediately report such condition to the department by oral communication and by making a written report within forty-eight hours after such oral communication; provided, however, that whenever such person so required to report is a member of the staff of a medical or other public or private institution, school or facility, he shall immediately either notify the department or notify the person in charge of such institution, school or facility, or that person's designated agent, whereupon such person in charge or his said agent shall then become responsible to make the report in the manner required by this section. Any such hospital personnel preparing such report, may take, or cause to be taken, photographs of the areas of trauma visible on a child who is the subject of such report without the consent of the child's parents or guardians. All such photographs or copies thereof shall be sent to the department together with such report. Any such person so required to make such oral and written reports who fails to do so shall be punished by a fine of not more than one thousand dollars.

Said reports shall contain the names and addresses of the child and his parents or other person responsible for his care, if known; the child's age; the child's sex; the nature and extent of the child's injuries, abuse, maltreatment, or neglect, including any evidence of prior injuries, abuse maltreatment, or neglect; the circumstances under which the person required to report first became aware of the child's injuries, abuse, maltreatment or neglect; whatever action, if any, was taken to treat, shelter, or otherwise assist the child; the name of the person or persons making such report; and any other information which the person reporting believes might be helpful in establishing the cause of the injuries; the identity of the person or persons responsible therefor; and such other information as shall be required by the department.

Any person required to report under this section who has reasonable cause to believe that a child has died as a result of any of the conditions listed in said paragraph shall report said death to the department and to the district attorney for the county in which such death occurred and to the medical examiners as required by section six of chapter thirty-eight. Any such person who fails to make such a report shall be punished by a fine of not more than one thousand dollars.

In addition to those persons required to report pursuant to this section, any other person may make such a report if any such person has reasonable cause to believe that a child is suffering from or has died as a result of such abuse or neglect. No person so required to report shall be liable in any civil or criminal action by reason of such report. No other person making such report shall be liable in any civil or criminal action by reason of such report if it was made in good faith; provided, however, that such person did not perpetrate or inflict said abuse or cause said neglect. Any person making such report who, in the determination of the department or the district attorney may have perpetrated or inflicted said abuse or cause said neglect, may be liable in a civil or criminal action.

Within sixty days of the receipt of a report by the department from any person required to report, the department shall notify such person, in writing, of its determination of the nature, extent and cause or causes of the injuries to the child, and the social services that the department intends to provide to the child or his family.

Any privilege established by section one hundred and thirty-five of chapter one hundred and twelve or by section twenty B of chapter two hundred and thirty-three, relating to confidential communications shall not prohibit the filing of a report pursuant to the provisions of this section or the provisions of section twenty-four.

Added by St.1973, c. 1076, § 5. Amended by St.1975, c. 276, § 4; St.1977, c. 501; St.1977, c. 942; St.1978, c. 215, § 1; St.1979, c. 312, § 1; St.1980, c. 434; St.1981, c. 91, § 2; St.1982, c. 102; St.1983, c. 222; St.1984, c. 83, §§ 1, 2; St.1985, c. 209.

1973 Enactment. This section was derived from former §§ 39A and 39C of this chapter.

St.1973, c. 1076, § 5, adding this section and §§ 51B to 51G of this chapter, was approved Nov. 21, 1973.

1975 Amendment. St.1975, c. 276, § 4, substituted "eighteen" for "sixteen" years in the first paragraph.

St.1975, c. 276, was approved June 2, 1975. Emergency declaration by the Governor was filed June 3, 1975.

§ 51B. Physically or emotionally injured children; duties of department

The department shall:

(1) investigate and evaluate the information reported under section fifty-one A. Said investigation and evaluation shall be made within twenty-four hours if the department has reasonable cause to believe the child's health or safety is in immediate danger from further abuse or neglect and within seven days for all other such reports. The investigation shall include a home visit at which the child is viewed, if appropriate, a determination of the nature, extent and cause or causes of the injuries, the identity of the person or persons responsible therefor, the name, age and condition of other children in the same household, an evaluation of the parents and the home environment, and all other pertinent facts or matters. Such determinations and evaluations shall be in writing;

(2) evaluate the household of the child named in the report and make a written determination of the risk of physical or emotional injury to any other children in the same household;

(3) take a child into immediate temporary custody if the department has reasonable cause to believe that the removal of the child is necessary to protect him from further abuse or neglect; provided, however, that the department shall make a written report stating the reasons for such removal; and provided further, that if any child is so taken into custody, the department must file a petition pursuant to section twenty-four on the next court day;

(4) notify in writing the district attorney for the county in which the child resides by transmitting to such district attorney a copy of the report required under section fifty-one A and this section if, after an investigation and evaluation undertaken pursuant to clause (1), the department has reasonable cause to believe that any of the following conditions has resulted from abuse or neglect:

(*a*) a child has died;

(b) a child has been sexually assaulted, as set forth in sections thirteen B, thirteen H, twenty-two, twenty-two A, twenty-three, twenty-four, and twenty-four B of chapter two hundred and sixty-five or section thirty-five A of chapter two hundred and seventy-two.

(*c*) a child has suffered brain damage, loss or substantial impairment of a bodily function or organ, or substantial disfigurement;

(*d*) a child has been sexually exploited, which shall mean encouraging a child to engage in prostitution as defined in sections four A and four B of chapter two hundred and seventy-two or in the obscene or pornographic photographing, filming, or depicting of a child as defined in section twenty-nine A of chapter two hundred and seventy-two; or

(*e*) a child has suffered serious bodily injury as the result of a pattern of repetitive actions by a family member.

The department shall within forty-five days after making such notification further notify the district attorney of the service plan, if any, developed for such child and his family. No provision of chapter sixty-six A, section one hundred and thirty-five of chapter one hundred and twelve, and sections fifty-one E and fifty-one F of this chapter relating to confidential data or confidential communications shall prohibit the department from making such notifications or from providing to the district attorney any information obtained pursuant to clause (1) or furnished pursuant to this clause. No person providing notification or information to a district attorney pursuant to the provisions of this clause shall be liable in any civil or criminal action by reason of such action. Nothing herein shall be construed to prevent the department from notifying a district attorney relative to any incidents reported to the department pursuant to section fifty-one A or to limit the prosecutorial power of a district attorney.

(5) offer to the family of any child which it has reasonable cause to believe is suffering from any of the conditions described in the report appropriate social services to prevent further injury to the child, to safeguard his welfare, and to preserve and stabilize family life whenever possible. If the family declines or is unable to accept or to participate in the offered services, the department, or any person may file a petition pursuant to section twenty-four requesting an appropriate order with reference to the care and protection of the child;

(6) file in the central registry established under section fifty-one F a written report containing information sufficient to identify each child whose name is reported pursuant to section fifty-one A or fifty-one B. A notation shall be sent to such central registry whenever further reports on each such child are filed with the department;

(7) utilize or purchase and utilize such protective services of private and voluntary agencies as it determines necessary;

(8) promulgate regulations to implement the provisions of sections fifty-one A to fifty-one F, inclusive.

(9) notify in writing the office for children by transmitting to said office a copy of the report received under section fifty-one A and a copy of the report prepared under section fifty-one B if and when such report alleges that abuse or neglect occurred at a facility operated by a person subject to licensure or approval by said office under section ten of chapter twenty-eight A, and when the department has substantiated said report. Said department and said office may coordinate their activities conducted under this section and paragraph (f) of said section ten. No provision of chapter sixty-six A, section one hundred and thirty-five of chapter one hundred and twelve, sections fifty-one E and fifty-one F of this chapter, or any other provision of law, shall prohibit the department from transmitting a copy of the reports prepared under the provisions of sections fifty-one A and fifty-one B to said office, or from conducting coordinated activities and sharing information with said office as herein provided, or from having its employees testify at administrative hearings held by said office in connection with matters about which said department has provided notice to said office under this section. Said department and said office shall make all reasonable efforts to minimize the number of interviews of any child-victim which may be necessary. If as a result of any report made under the provisions of said section fifty-one A or an investigation made under the provisions of said section fifty-one B, said department is made aware of information or circumstances indicating a licensing violation in any facility operated by a person subject to licensure or approval by said office, said department shall forthwith notify said office of such information. No provision of chapter sixty-six A, sections fifty-one E and fifty-one F of this chapter, or any other provision of law shall prohibit said office from providing information to said department in connection with matters about which said department has provided notice to said office under this section.

(10) notify in writing the department of mental health, the department of public health, and the department of youth services by transmitting to any of said departments a copy of the report received under section fifty-one A and a copy of the report prepared under section fifty-one B if and when that report alleges that abuse or neglect occurred at a facility owned, operated or funded, in whole or in part, by any of said departments, and when the department of social services has substantiated said report. Said department of social services and any of said departments may coordinate their respective activities conducted under this section, and shall make all reasonable efforts to minimize the number of interviews of any child-victim which may be necessary. No provision of chapter sixty-six A, section one hundred and thirty-five of chapter one hundred and twelve, sections fifty-one E and fifty-one F of this chapter, or any other provision of law, shall prohibit said department of social services from transmitting a copy of said reports made under the provisions of said sections fifty-one A and fifty-one B to any of said departments or from conducting coordinated activities and sharing information with any of said departments as herein provided, or from having its employees testify at administrative hearings held by any of said departments in connection with matters about which said department of social services has provided notice to any of said departments under this section.

Added by St.1973, c. 1076, § 5. Amended by St.1978, c. 131; St.1983, c. 288, § 2; St.1984, c. 87; St.1985, c. 343; St.1985, c. 776, § 2.

1973 Enactment. This section was derived from former § 39B of this chapter.

See, also, the note under § 51A of this chapter.

1978 Amendment. St.1978, c. 131, approved May 5, 1978, substituted "make a written determination of" for "determine" in cl. (2); inserted "that the department shall make a written report stating the reasons for such removal; and provided further" in cl. (3); and rewrote cl. (1) which prior thereto read: "(1) investigate and evaluate the information reported under section fifty-one A. The investigation shall include a determination of the nature, extent and cause or causes of the injuries, the identity of the person or persons responsible therefor, the name, age and condition of other children in the same household, an evaluation of the parents and the home environment, and all other pertinent facts or matters;".

1983 Amendment. St.1983, c. 288, § 2, approved July 14, 1983, inserted cl. (4) and renumbered former cls. (4) to (7) as cls. (5) to (8).

1984 Amendment. St.1984, c. 87, approved June 15, 1984, in cl. (4), in the introductory paragraph inserted "and this section", in subd. (b) inserted "twenty-two,", and in the second sentence of the last paragraph of cl. (4) inserted "or punished pursuant to this clause".

THE COMMONWEALTH OF MASSACHUSETTS

In the Year One Thousand Nine Hundred and Eighty-five

AN ACT AUTHORIZING THE VIDEOTAPING OF CERTAIN TESTIMONY.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Chapter 278 of the General Laws is hereby amended by inserting after section 16C the following section:-

Section 16D. (a) For the purposes of this section, the following words shall have the following meanings:-

"Child witness", a person who is under the age of fifteen years and who is alleged to have been a victim of, or a witness to an alleged violation of section thirteen B, thirteen F, thirteen H, twenty-two, twenty-two A, twenty-three, twenty-four or twenty-four B of chapter two hundred and sixty-five, or section two, three, four, four A, four B, five, six, seven, eight, twelve, thirteen, sixteen, seventeen, twenty-four, twenty-eight, twenty-nine, twenty-nine A, twenty-nine B, thirty-three, thirty-four or thirty-five A of chapter two hundred and seventy-two.

"Simultaneous electronic means", Any device capable of projecting a live visual and aural transmission such as closed-circuit television.

(b) (1) At any time after the issuance of a complaint or indictment alleging an offense punished by any of the statutes listed herein, the court on its own motion or on motion of the proponent of a child witness, and after a hearing, may order the use of a suitable alternative procedure for taking the testimony of the child witness, in proceedings pursuant to said complaint or indictment, provided that the court finds by a preponderance of the evidence at the time of the order that the child witness is likely to suffer psychological or emotional trauma as a result of testifying in open court, as a result of testifying in the presence of the defendant, or as a result of both of testifying in open court and of testifying in the presence of the defendant. If the court orders the use of a suitable alternative for taking the testimony of a child witness pursuant to this section, the court shall make and enter specific findings upon the record describing with particularity the reasons for such order.

(2) An order issued under paragraph (1) shall provide that the testimony of the child witness be recorded on videotape or film to be shown in court at a later time or that the testimony be transmitted to the courtroom by simultaneous electronic means.

(3) Testimony taken by an alternative procedure pursuant to an order issued under paragraph (1) shall be taken in the presence of the judge, the prosecutor, defense counsel and such other persons as the court may allow. The defendant shall also have the right to be present unless the court's order under paragraph (1) is based wholly or in part upon a finding that the child witness is likely to suffer trauma as a result of testifying in the presence of the defendant. If the order is based on such a finding, the testimony of the child witness shall not be taken in the presence of the defendant except as provided in paragraph (4).

(4) Testimony taken by an alternative procedure pursuant to an order issued under paragraph (1) shall be taken in a suitable setting outside the courtroom, except that an order based only on a finding that the child witness is likely to suffer trauma as a result of testifying in the presence of the defendant may provide that the testimony be taken in a suitable setting inside the courtroom in a manner so that the child witness is not able to see or hear the defendant.

(5) When testimony is taken by an alternative procedure pursuant to an order issued under paragraph (1), counsel shall be given the opportunity to examine or cross-examine the child witness to the same extent as would be permitted at trial, and the defendant shall be able to see and hear the child witness and to have constant private communication with defense counsel.

(6) The film, videotape or transmission of testimony taken by an alternative procedure pursuant to an order issued under paragraph (1) shall be admissible as substantive evidence to the same extent as and in lieu of live testimony by the child witness in any proceeding for which the order is issued or in any related criminal proceeding against the same defendant when consistent with the interests of justice, provided that such an order is entered or re-entered based on current findings at the time when or within a reasonable time before the film, videotape or transmission is offered into evidence. Subsequent testimony of a child witness in any such proceeding shall also be taken by a suitable alternative procedure pursuant to this section.

(7) Whenever pursuant to an order issued under paragraph (1), testimony is recorded on videotape or film or is transmitted to the courtroom by simultaneous electronic means, the court shall ensure that:

(a) The recording or transmitting equipment is capable of making an accurate recording or transmission and is operated by a competent operator;

(b) The recording or transmission is in color and the witness is visible at all times;

(c) Every voice on the recording or transmission is audible and identified;

(d) The courtroom is equipped with monitors which permit the jury and others present in the courtroom to see and hear the recording or transmission;

(e) In the case of recorded testimony, the recording is accurate and has not been altered;

(f) In the case of recorded testimony, each party is afforded the opportunity to view the recording before it is shown in the courtroom.

(8) Nothing in this section shall be deemed to prohibit the court from using other appropriate means, consistent with this section and other laws and with the defendant's rights, to protect a child witness from trauma during a court proceeding.

House of Representatives, December 18, 1985.

Passed to be enacted, Mary Jane Gibson, Acting Speaker.

In Senate, December 18, 1985.

Passed to be enacted, William M. Bulger, President.

December 30, 1985.

Approved,

Michael S. Dukakis, Governor.

§ 13B. Indecent assault and battery on child under fourteen; penalties; subsequent offenses; eligibility for parole, etc.

Whoever commits an indecent assault and battery on a child under the age of fourteen shall be punished by imprisonment in the state prison for not more than ten years, or by imprisonment in a jail or house of correction for not more than two and one-half years; and whoever commits a second or subsequent such offense shall be punished by imprisonment in the state prison for life or any term of years.

No person serving a sentence for a second or subsequent such offense shall be eligible for furlough, temporary release, or education, training or employment programs established outside a correctional facility until such person shall have served two-thirds of such minimum sentence or if such person has two or more sentences to be served otherwise than concurrently, two-thirds of the aggregate of the minimum terms of such several sentences.

Amended by St.1980, c. 459, § 4.

1980 Amendment. St.1980, c. 459, § 4, in the first paragraph substituted "ten years" for "five years", "by imprisonment in a jail or house of correction" for "in jail", and "one-half" for "one half", deleted "or by a fine of not more than five hundred dollars" following "two and one-half years" and added the second paragraph.

Section 11 of St.1980, c. 459, provided:

"The clerk of each court of the commonwealth having criminal jurisdiction over sections thirteen B, thirteen H, twenty-two, twenty-two A, twenty-three, twenty-four, and twenty-four B of chapter two hundred and sixty-five of the General Laws shall make a detailed report of persons and proceedings under said sections. Such report shall indicate the specific violation charged, the status of such charges, the disposition of such charges, the age and prior criminal record of the defendant, a description of the sentence imposed, if any, appeal, if any, of the sentence and the final disposition of any such sentence, on forms approved by the administrative justices of the district and superior court department of the trial court. The defendant's name shall be expunged from all such reports.

"All persons required to make such reports shall file such reports every third month, beginning September first, nineteen hundred and eighty, with the clerk of the house of representatives. If no person has been prosecuted for violations of the aforementioned sections, the clerks shall certify to such fact in such reports."

St.1980, c. 459, was approved July 10, 1980. Emergency declaration by the Governor was filed July 11, 1980.

Code of Massachusetts Regulations

Correctional facilities, special offenders, furloughs, see 103 CMR 463.06.

Cross References

Child witness testimony at trial for alleged violation of this section, videotaping or transmission by simultaneous electronic means, see c. 278, § 16D.

Prisoners serving sentence for violating this section, participation in employment program on municipal properties, see c. 127, § 49C.

Sexually assaulted children, duties of department of public welfare, see c. 119, § 51B.

Venue, see § 24A of this chapter.

§ 23. Rape and abuse of child

Whoever unlawfully has sexual intercourse or unnatural sexual intercourse, and abuses a child under sixteen years of age shall, for the first offense, be punished by imprisonment in the state prison for life or for any term of years, or, except as otherwise provided, for any term in a jail or house of correction, and for the second or subsequent offense by imprisonment in the state prison for life or for any term of years, but not less than five years.

Amended by St.1974, c. 474, § 3.

1974 Amendment. St.1974, c. 474, § 3, approved July 3, 1974, substituted "has sexual intercourse or unnatural sexual intercourse" for "and carnally knows", and substituted "a jail or house of correction" for "any other penal institution in the commonwealth".

Code of Massachusetts Regulations

Correctional facilities,
  Cadre positions, eligibility, see 103 CMR 453.08.
  Special offenders, furloughs, see 103 CMR 463.06.

Cross References

Chemical analysis for sperm cells or seminal fluid, chemist's certificate as prima facie evidence, see c. 147, § 4F.

Child witness testimony at trial for alleged violation of this section, videotaping or transmission by simultaneous electronic means, see c. 278, § 16D.

Evidence of sex crime victim's sexual conduct, admissibility, see c. 233, § 21B.

Limitation of criminal prosecutions for violating this section, conspiracy, to violate, etc., see c. 277, § 63.

Physically or emotionally injured children, department of social services to notify district attorney of violations of this section, see c. 119, § 51B.

Prisoners serving sentence for violating this section, participation in employment program on municipal properties, see c. 127, § 49C.

Law Review Commentaries

Child abuse: In search of a proper defendant. (1978) 13 New England L.Rev. 802.

Rape-shield law: Over-step in the right direction. Charles M. Burnim (1979) 64 Mass.L. Rev. 61.

Rights of child witnesses. Jacqueline Y. Parker (1981-1982) 17 New England L.Rev. 643.

Statutory rape; reasonable mistake of age as affirmative defense. 18 Annual Survey of Mass. Law, Boston College, p. 533 (1971).

Library References

Comment.

Rape of child, see M.P.S. vol. 32, Nolan, §§ 230, 231, 233.

United States Supreme Court

Death penalty for rape, see Coker v. Georgia, 1977, 97 S.Ct. 2861, 433 U.S. 584, 53 L.Ed.2d 982.

§ 22A. Rape of child; use of force

Whoever has sexual intercourse or unnatural sexual intercourse with a child under sixteen, and compels said child to submit by force and against his will or compels said child to submit by threat of bodily injury, shall be punished by imprisonment in the state prison for life or for any term of years; and whoever over the age of eighteen commits a second or subsequent such offense shall be sentenced to the state prison for life or for any term of years, but not less than five years.

Amended by St.1973, c. 925, § 77; St.1974, c. 474, § 2.

1973 Amendment. St.1973, c. 925, § 77, substituted "eighteen" for "twenty-one".

St.1973, c. 925, was approved Oct. 17, 1973, and by § 84 made effective Jan. 1, 1974. Emergency declaration by the Governor was filed Dec. 20, 1973.

1974 Amendment. St.1974, c. 474, § 2, approved July 3, 1974, substituted "has sexual intercourse or unnatural sexual intercourse with a child under sixteen, and compels said child to submit by force and against his will or compels said child to submit by threat of bodily injury," for "ravishes and carnally knows a female child under sixteen by force and against her will".

Code of Massachusetts Regulations

Correctional facilities, special offenders, furloughs, see 103 CMR 463.06.

Cross References

Child witness testimony at trial for alleged violation of this section, videotaping or transmission by simultaneous electronic means, see c. 278, § 16D.

Evidence of sex crime victim's sexual conduct, admissibility, see c. 233, § 21B.

Limitation of criminal prosecutions for violating this section, conspiracy to violate, etc., see c. 277, § 63.

Physically or emotionally injured children, department of social services to notify district attorney of violations of this section, see c. 119, § 51B.

Prisoners serving sentence for violating this section, participation in employment program on municipal properties, see c. 127, § 49C.

Venue, see § 24A of this chapter.

Law Review Commentaries

Admissibility of extrajudicial rape complaints. (1984) 64 Boston U.L.Rev. 199.

Child abuse: In search of a proper defendant. (1978) 13 New England L.Rev. 802.

Rape-shield law: Over-step in the right direction. Charles M. Burnim (1979) 64 Mass.L. Rev. 61.

Rights of child witnesses. Jacqueline Y. Parker (1981-1982) 17 New England L.Rev. 643.

Library References

Comment.

Rape of child, see M.P.S. vol. 32, Nolan, §§ 230, 231, 233.

United States Supreme Court

Death penalty for rape, see Coker v. Georgia, 1977, 97 S.Ct. 2861, 433 U.S. 584, 53 L.Ed.2d 982.

COMPLAINT FOR PROTECTION FROM ABUSE (G.L. c. 209A)

FOR COURT USE ONLY →

DOCKET NO.

TRIAL COURT OF MASSACHUSETTS

PART 1
☐ BOSTON MUNICIPAL COURT
☐ DISTRICT COURT ____________ DIVISION
☐ PROBATE & FAMILY COURT ____________ DIVISION
☐ SUPERIOR COURT ____________ COUNTY

PART 2
NAME OF PLAINTIFF (the person seeking protection)

PART 3

3A
Write your address here if you want it to be kept **CONFIDENTIAL** (that is, impounded).
____
____
Phone No: (____) ______________

3B
Write your address here if you do **NOT** want it to be kept confidential.
____
____
Phone No: (____) ______________

PART 4
If you left a former residence to avoid abuse, write that address here:
____
____

PART 5
Your attorney (if any):
Name ______________________________
Address ______________________________
____
Phone No: (____) ______________

PART 6
NAME & ADDRESS OF DEFENDANT (the person causing abuse)
____
____
____
Phone No: (____) ______________

PART 7
CHECK AS MANY AS APPLY:
☐ The defendant and I are members of the same household.
☐ The defendant and I are currently married to each other.
☐ The defendant and I were formerly married to each other.
☐ I am the defendant's child.
☐ I am the defendant's parent.
☐ I am a blood relative of the defendant; specifically, the defendant is my: ______________________________
____
____

PART 8
I ☐ have ☐ have not previously sought protection from abuse in any Massachusetts court.
There ☐ is ☐ is not a pending or concluded action for divorce or separate support between the defendant and me.

PART 9
I ☐ am ☐ am not under the age of eighteen.
The defendant ☐ is ☐ is not under the age of eighteen.

PART 10
On or about *(dates)* ______________________________ I suffered abuse when the defendant:
☐ attempted to cause me physical harm.
☐ caused me physical harm.
☐ placed me in fear of imminent serious physical harm.
☐ caused me unwillingly to engage in sexual relations by force, threat of force, or duress.

Therefore:
☐ 1. I ask the Court to order the defendant to stop abusing me.
☐ 2. I ask the Court to order the defendant immediately to leave and remain away from the household which is located at:
____
☐ 3. Since the defendant and I are husband and wife, I ask the Court to award me temporary custody of the following minor child(ren) *(separate affidavit must also be filed - see instructions on reverse side)*:

NAME	DATE OF BIRTH

☐ 4. I ask the Court to order the defendant to pay temporary support:
☐ to me. ☐ to any child in my custody. ☐ to both.
☐ 5. I ask the Court to order the defendant to pay me $ ____________ for the following losses suffered as a direct result of the abuse: ______________________________
____

PLEASE NOTE
You may not obtain an Order from the Boston Municipal Court or a District Court covering items (3), (4) or (5) in Part 10 if there is a pending Order in an action for divorce or separate support in the Probate and Family Court between you and the defendant.

☐ 6. I ask the Court to impound my address to prevent its disclosure to the defendant, the defendant's attorney, or the public.
☐ 7. I ask the Court to order the following: ______________________________
____
____
☐ 8. I ask the Court to order the relief I have requested above, except for (4) and (5), without advance notice to the defendant because there is a substantial likelihood of immediate danger of abuse. I understand that if the Court issues such a temporary Order, the Court will schedule a hearing within 5 days to determine whether such a temporary Order should be continued, and that I must appear in court on that day.

DATE

PLAINTIFF'S SIGNATURE
X

COURT COPY

§ 3. Remedies; period of relief

A person suffering from abuse from an adult or minor family or household member may file a complaint in the court requesting protection from such abuse, including, but not limited to, the following orders:—

(*a*) ordering the defendant to refrain from abusing the plaintiff whether the defendant is an adult or minor;

(*b*) ordering the defendant to vacate forthwith the household. Notwithstanding the provisions of section thirty-four B of chapter two hundred and eight, an order to vacate shall be for a fixed period of time, not to exceed one year, at the expiration of which time the court may extend any such order upon motion of the plaintiff for such additional times as it deems necessary to protect the plaintiff from abuse;

(*c*) awarding the plaintiff, in the case of husband and wife, temporary custody of a minor child;

(*d*) ordering the defendant to pay temporary support for the plaintiff or any child in the plaintiff's custody or both, when the defendant has a legal obligation to support such a person;

(*e*) ordering the defendant to pay to the person abused monetary compensation for losses suffered as a direct result of such abuse. Compensatory losses shall include, but not be limited to, loss of earnings or support, out-of-pocket losses for injuries sustained, medical and moving expenses and reasonable attorneys' fees;

(*f*) ordering the plaintiff's address to be impounded as provided in section eight.

No filing fee shall be charged for the filing of the complaint. The plaintiff shall not be charged for copies of orders entered by the court.

Any relief granted by the court shall be for a fixed period of time not to exceed one year, at the expiration of which time the court may extend any order, upon motion of the plaintiff, for such additional time as it deems necessary to protect the plaintiff from abuse. The court may modify its order at any subsequent time upon motion by either party.

No order under this chapter shall in any manner affect title to real property.

Any action commenced under the provisions of this chapter shall not preclude any other civil or criminal remedies. A party filing a complaint under this chapter shall be required to disclose any prior or pending actions for divorce under chapter two hundred and eight, separate support under two hundred and nine, or abuse prevention under this chapter.

If there is a prior or pending order from the probate and family court department of the trial court for divorce under chapter two hundred and eight, or separate support under chapter two hundred and nine, an order issued in the district court or Boston municipal court departments pursuant to this chapter shall be restricted to ordering the defendant to refrain from abusing the plaintiff whether the defendant is an adult or minor, or ordering the defendant to vacate forthwith the household.

If the parties to a proceeding under this chapter are parties in a subsequent proceeding for divorce under chapter two hundred and eight or for separate support under chapter two hundred and nine, any custody or support order or judgment issued in the divorce or separate support proceeding shall supersede any prior custody or support order under this chapter.

Added by St.1978. c. 447, § 2. Amended by St.1983, c. 678, § 4.

1978 Enactment. St.1978, c. 447, § 6, provided:

"The chief justice of the superior court and the chief judge of the probate court and the chief justice of the district courts shall jointly promulgate a form of petition for chapter two hundred and nine A of the General Laws, inserted by section one of this act [so in enrolled bill; should read "section two of this act"], which shall be simple and permit a person to file a petition himself."

1983 Amendment. St.1983, c. 678, § 4, approved Dec. 21, 1983, in the first paragraph substituted "complaint in the court requesting protection from such abuse, including, but not limited to, the following orders:" for "petition in the district, probate or superior court requesting any order which will protect him from abuse, including, but not limited to the following:", in cl. (b) added the second sentence, in cl. (c) substituted "husband and" for "husband or" and added "child", in cl. (d) deleted a comma following "custody" and inserted "a" preceding "person", in cl. (e), in the second sentence, inserted "medical and" and substituted "attorneys' " for "attorney", and added cl. (f); in the second paragraph, in the first sentence, substituted "the filing of the complaint" for "such a petition", and added the second sentence; in the fourth paragraph deleted "any" preceding "real property"; in the fifth paragraph, in the first sentence substituted "action commenced under the provisions of this chapter" for "proceedings under this chapter", and added the second sentence; and added the sixth and seventh paragraphs.

Notes of Decisions

1. Purpose of law

Indication of legislative purpose in Domestic Violence Act constituted clear legislative statement of public policy which Supreme Judicial Court would try to advance in its construction of rape statute (c. 265, § 22). Com. v. Chretien (1981) 417 N.E.2d 1203, 383 Mass. 123.

LICENSING OF SOCIAL WORKERS

§ 135. Confidential information; disclosure prohibited; exceptions

No social worker in any licensed category, including those in private practice, and no social worker employed in a state, county or municipal governmental agency, shall disclose any information he may have acquired from a person consulting him in his professional capacity or whom he has served in his professional capacity except:

(a) with the written consent of such person or, in the case of death or disability of such person, of his representative, other person authorized to sue, or the beneficiary of an insurance policy on his life, health, or physical condition;

(b) that a licensed certified social worker, including one engaged in independent clinical practice, licensed social worker, licensed social work associate, or a social worker employed in a state, county, or municipal agency, shall not be required to treat as confidential a communication that reveals the contemplation or commission of a crime or harmful act;

(c) when the person waives the privilege by bringing charges against the licensed certified social worker, including one engaged in independent clinical practice, the licensed social worker, the licensed social work associate or by a social worker employed in a state, county, or municipal agency;

(d) to initiate a proceeding under subsection C of section twenty-three of chapter one hundred and nineteen or section twenty-four of said chapter one hundred and nineteen, or section three of chapter two hundred and ten and give testimony in connection therewith;

(e) in any other child custody case in which, upon a hearing in chambers, the judge, in the exercise of his discretion, determines that the social worker has evidence bearing significantly on the person's ability to provide suitable custody, and that it is more important to the welfare of the child that the information be disclosed than that the relationship between the person and social worker be protected;

(f) where the social worker has acquired the information while conducting an investigation pursuant to section fifty-one B of chapter one hundred and nineteen.

Amended by St.1985, c. 524.

her from time to time ever since she was born. In his opinion, the plaintiff was an "alert youngster who would compare with any average child her age in intelligence." On cross-examination he testified that as to her capacity at the age of three to remember and relate what happened to her the same day "there would be no way of really knowing; except that if they go through any experience you can usually gauge a great deal by their emotional reactions at the time of an examination." The doctor was then asked, "What would your opinion be . . . of a normal child's capacity such as Karen, who is now, as I understand it, eight years old, relating something that happened to her when she was three years and three months old?" His answer was, "I doubt very much whether she could really explain fully just what happened in such a long period of time."

Karen then was called as a witness and was sworn Before she gave any testimony, the defendants objected to her testifying "on the grounds that she was an incompetent witness; that at the age of eight . . . she was now going to be asked to relate an incident that happened when she was three." The objection was overruled and Karen was permitted to testify, subject to the defendants' exception. There was no voir dire and none was requested. We do not construe the objection as raising the question whether Karen possessed the "sufficient understanding" necessary to qualify her as a witness under G. L. c. 233, § 20. As the objection was worded, the judge could rightly assume that the sole basis of it was whether the witness should be allowed to testify to events which occurred when she was three years and three months old.

We might add that the evidence of Karen's competency to testify in general was ample. Karen, who was eight and one-half years old at the time of trial, testified that she was in the third grade at school, attended church often, and had been taught what it means to tell the truth and the consequences of not telling the truth. In addition, there was the testimony of Dr. Berson, recited above. The test of competency is not age but the capacity to understand and communicate coupled with a consciousness of the duty to speak the truth. Wigmore on Evidence (3d ed.) § 506. McCormick on Evidence, § 62. *Commonwealth* v. *Hutchinson*, 10 Mass. 225. *Commonwealth* v. *Robinson*, 165 Mass. 426. *Commonwealth* v. *Teregno*, 234 Mass. 56, 59. *Commonwealth* v. *Tatisos*, 238 Mass. 322. *Commonwealth* v. *Welcome*, 348 Mass. 68, 70.

The defendants' objection in effect asked the judge to rule as matter of law that Karen could not testify as to the earlier events which occurred when she was slightly more than three years old. At the time the objection was made, Dr. Berson, Karen's pediatrician, had testified. His testimony (summarized above) afforded some, albeit slight, basis for allowing her to testify to the earlier events. Dr. Berson's doubt "whether she could really explain *fully* just what happened in such a long period of time" was not an opinion that she was incapable of remembering anything (emphasis supplied). Karen testified to what happened when she was injured. It appeared that she remembered the events which occurred when she was injured and was able to communicate her recollection. The defendants' counsel cross-examined her at some length. The examination was directed to testing her memory as to past events and as to whether she was testifying as to what she had been told. Her version was not shaken to any appreciable extent.

The defendants complain that there should have been a preliminary examination by the judge before Karen was permitted to testify. Usually when there is a question of the competency of a child to testify, the matter is determined by the judge on a voir dire examination. This is made clear in *Commonwealth* v. *Reagan*, 175 Mass. 335, where in an illuminating opinion by Hammond, J., the matter is exhaustively discussed with ample citation of authorities. But strictly speaking the question was really not one of competency. The distinction between competency on the one hand and the requisite knowledge on the other is well illustrated by the following comments in the Model Code of Evidence.

THE COMMONWEALTH OF MASSACHUSETTS

In the Year One Thousand Nine Hundred and Eighty-six

AN ACT RELATIVE TO THE REPORTING OF CERTAIN CHILD ABUSE CASES.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. The first sentence of the first paragraph of section 51A of chapter 119 of the General Laws, as amended by chapter 209 of the acts of 1985, is hereby further amended by inserting after the word "worker", in line 6, the following words:- or any person paid to care for or work with a child in any public or private facility, or home or program funded by the commonwealth or licensed pursuant to the provisions of chapter twenty-eight A, which provides day care or residential services to children.

SECTION 2. Said section 51A of said chapter 119 is hereby further amended by inserting after the fourth paragraph the following paragraph:-

No employer of those persons required to report pursuant to this section shall discharge, or in any manner discriminate or retaliate against, any person who in good faith makes such a report, testifies or is about to testify in any proceeding involving child abuse or neglect. Any such employer who discharges, discriminates or retaliates against such a person shall be liable to such person for treble damages, costs and attorney's fees.

House of Representatives, July 3, 1986.

Passed to be enacted, George Keverian, Speaker.

In Senate, July 3, 1986.

Passed to be enacted, William M Bulger, President.

July 15, 1986.

Approved,

Governor.

The Medical Examination

This Section of the Manual
has been adapted from
the Child Maltreatment Protocol,
University of Massachusetts
Medical Center.

INTRODUCTION

Child maltreatment is a major physical and mental health problem for which social, familial, psychological, and physiological risk factors have been identified. Physicians and other health professionals play critical roles in identifying, reporting, and planning treatment for abused or neglected children. Four main tasks emerge:

First is a medical examination of the child. Care must be taken in making a differential diagnosis as maltreatment can mimic organic and psychosocial disease. Organic diseases and parenting practices may mimic abuse.

Second is a careful documentation of findings. Protective services and legal personnel will often turn to these examinations as the sole source of physical evidence.

Third is the protection of the child from further maltreatment.

Fourth is the referral and communication of information to appropriate ongoing services.

The main task of medical personnel is that of promoting the care and protection of the child whose health is being threatened, and not determining the perpetrator of the act. A nonjudgemental, nonhostile approach is the best means of gaining cooperation of the individuals involved.

THE MEDICAL HISTORY

In cases of possible child maltreatment, the history should be obtained prior to the physical examination whenever possible.

The history should be obtained in a nonjudgemental manner. Except in the case of very young children, the child and each parent should be interviewed separately to obtain independent accounts. Careful documentation of the details of any apparent or alleged injury or episode of abuse or neglect is crucial.

Ask the parent to describe the present illness or injury, the child's past history (including medical, developmental, and social information), school performance, and the family situation. The parent should also be asked to describe their perceptions of the child's behavior and attitudes, of current family situations, of chronic or acute stress situations, and of available support systems.

The interview of the child should take place in private with the most experienced professional(s) available. With toddlers and many preschool children, this time is best spent in preparing the child for the physical examination. Preschoolers and older children are often able to give an account of the incident or event.

Children able to detail accounts of a situation rarely disclose information which is not true. They may present as being confused, but the events which they describe are usually accurate. Disclosures by children should be considered important and valid.

It is not uncommon for a child who has disclosed sexual abuse to retract or minimize its occurrence at a later date. When this happens, the child needs to be reassurred that he/she did the right thing by disclosing, and adults will protect the child from perpetrator threats, if any. Children should be told that they are not at fault for what has happened; they did not do anything wrong.

Sit at the child's eye level and take time to establish rapport. Ask about the situation in a manner appropriate to the child's developmental level and use the child's own terminology. The use of anatomically correct dolls or pictures may help the child to communicate. Do not suggest or press for answers.

THE PHYSICAL EXAMINATION

A careful and complete physical examination is indicated for all cases of suspected sexual abuse. It is important to remember that many children who have been sexually abused may have experienced other types of abuse and/or neglect. Comprehensive physical examination may reveal evidence of such abuse and/or neglect and help to substantiate the possibility of sexual abuse.

Children who have experienced acute sexual assault (<72 hours after the event) should be examined as soon as possible in a hospital with complete facilities and the ability to collect materials as specified in a Rape Evidence Collection Kit.

Children with a non-acute history of sexual abuse may be examined in an office setting with facilities for the culture of sexually transmitted diseases. The child's primary physician is the examiner of choice, if he/she is equipped to conduct the examination.

Preparation:

One should take care not to traumatize the child further by this examination. Therefore, use the time in gathering the history (described above) to establish rapport and gain the child's confidence. The presence of an adult trusted by the child will usually facilitate the establishment of rapport. Gear the examination to the child's developmental level which has been determined during history-taking. A brief general explanation may suffice with more detailed preparation before each part of the examination. The use of age-appropriate materials (dolls, pictures) may help illustrate certain procedures.

For example, before examining the genitalia you might say that you will first look and then gently touch with your fingers. Show the child the a swab and have him or her feel it. Describe how it will feel: "This swab feels soft just like a bunny's tail." It may be helpful to demonstrate the use of the swab on the doll or another object considered safe by the child.

The child should be reassured during the physical examination about normal findings since abused children (especially victims of sexual abuse) often feel themselves to be 'damaged goods.'

Examination of the Skin

The child's entire body should be examined for the presence of skin injuries. For any lesion, the shape, color, characteristics, location, and measurement should be recorded.

Bruises:

The following is an approximate guideline as to age. The child's own skin color may make determination of age difficult. The deeper injuries take longer to appear.

First 24 Hours	Reddish, blue, or purple
1 - 3 Days	Blue or blue/brown
5 - 7 Days	Greenish/blue
8 - 10 Days	Yellowish
2 - 4 Weeks	Brownish, then disappearing

Bruises indicating physical abuse include (1) those on any infant, especially facial bruises, (2) those on the posterior side of the body, (3) those in an unusual pattern, such as a hand print, crescentic bite mark, etc., (4) thumb print under the clavicles or reflecting the shape of an instrument, (5) clustered bruises indicating repeated contact with a hand or instrument, and (6) bruises in various stages of healing. Beware of clinical pitfalls, including bleeding disorders, lumbar (mongolian) spots, and inflammatory lesions.

Burns:

The distribution, degree, and measurement should be recorded. Patterns may include:

Immersion burns indicating dunking in a hot liquid ('sock' or 'glove' patterns on the arms and legs or 'donut' shapes on buttocks or genitalia where an area was spared contact with the container of liquid);

'Zebra' burns produced by pouring hot liquid or immersing the child with skin areas of maximum flexion spared;

Contact burns showing a distinct homogeneous pattern of the hot object (with a very uniform pattern when deliberate and one side worse than the other when accidental).

Beware of clinical pitfalls such as impetigo (which mimics cigarette burns), various bullous-producing diseases, and infections.

Lacerations and Abrasions:

These should be described and measured. Suspicious injuries include the following:

Lacerations of the lip, eye, or any portion of the face;
Any laceration or abrasion of the genitalia;
Abrasions on wrists or ankles or other places (indicating confinement);
Linear abrasions indicating whipping with a cord or rope.

HEENT EXAMINATION

A careful examination of the head, ears, eyes, nose, and throat must be performed. The following injuries could be the result of inflicted trauma:

Head:
- Alopecia or subgaleal hematoma from hair pulling;
- Subdural hematoma;
- Skull fractures;
- Jaw fractures.

Ears:
- Injury to pinna;
- Ruptured tympanic membrane resulting possibly from a blow to the side of the head or a basilar skull fracture.

Eyes:
- Orbital swelling;
- Retinal hemorrhage;
- Conjunctival hemorrhage;
- Hyphema;
- Corneal abrasion;
- Dislocation of lens;
- Detached retina.

Nose:
- Nasal fractures.

Mouth:
- Tooth fractures from blows to the chin;
- Teeth missing at unexpected time;
- Lacerated frenulum or intraoral trauma from force feeding.

ABDOMINAL EXAMINATION

The abdominal examination should be performed to look for signs of the following internal injuries which may be caused by blows to the midline of the abdomen:

- Duodenal or jejunal hematoma;
- Pancreatic injury with pancreatitis and pancreatic pseudocyst;
- Liver or spleen hematoma or laceration;
- Renal contusion or laceration;
- Retroperitoneal hemorrhage;
- Rupture of the inferior vena cava;
- Chylous ascites;
- Rupture of the ureter or bladder.

SKELETAL EXAMINATION

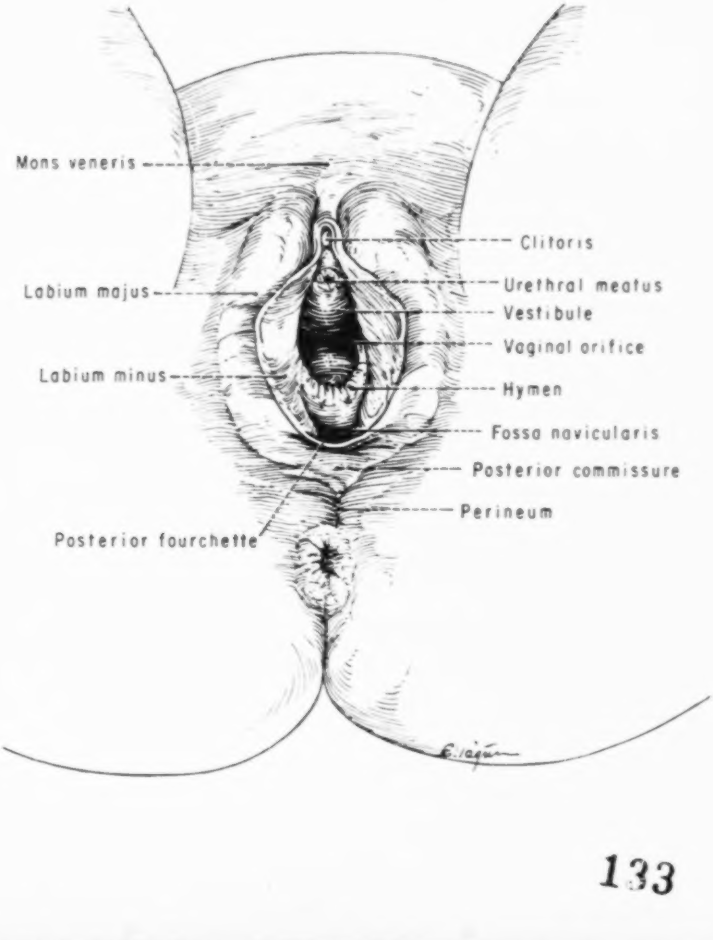
The child should be examined for evidence of acute or healing bony lesions. In cases of reasonable suspicion of trauma, a skeletal survey should be obtained. For any area of the body showing evidence of specific bony injury, plain films of that area should be obtained in addition to the skeletal survey.

GENITAL AND RECTAL EXAMINATION

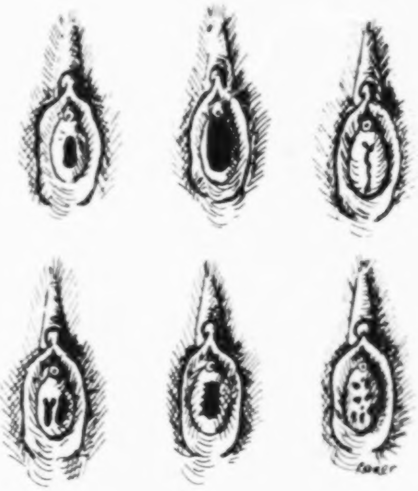
The child should be psychologically prepared prior to this part of the examination. That is, they should be told what will be done and how it will be done at a verbal skill-level consistent with the child's development. This important communication can be supplemented with the use of anatomically correct dolls. All children with alleged or suspected sexual abuse or assault require a careful and complete inspection of the external genitalia and rectum. Partial exams are never indicated, despite the localized nature of contact revealed by the history.

For females, an internal examination is required for:

1. Symptoms referrable to pelvic organs (abdominal pains, vaginal discharge, dysuria, etc.).
2. Findings on internal examination that may indicate penetration.
3. Any question regarding the nature or extent of the assault.


Mons veneris
Clitoris
Urethral meatus
Labium majus
Vestibule
Vaginal orifice
Labium minus
Hymen
Fossa navicularis
Posterior commissure
Perineum
Posterior fourchette

SOME HYMEN VARIATIONS



The examination may be modified according to the age of the child. The following list gives common variations.

1. Position for Inspection:
   Under Seven Years: Knee chest position in mother's lap/exam table or Lithotomy.
   Seven-Twelve Years: Knee-chest or Lithotomy.
   Over Twelve Years: Lithotomy.

2. Visualization:
   Under Seven years: Otoscope head.
   Seven-Twelve Years: Otoscope head or specula (Hoffman or baby H.).
   Over Twelve Years: Speculum (Hoffman or Pederson).

3. Specimen Collection:
   Under Seven Years: N-P Swab or Clinitest Dropper.
   Seven-Twelve Years: N-P Swab or Dropper.
   Over Twelve Years: Q-Tip or N-P Swab.

4. Palpation:
   Under Seven Years: Recto-abdominal, Bimanual.
   Seven-Twelve Years: Recto-abdominal or 1 Finger Vaginal, Abdominal.
   Over Twelve Years: 1-2 Finger Vaginal, Abdominal.

For females, describe any bruises, abrasions, lacerations, condyloma, discharge, dried secretions, edema, or erythema of the vulva or hymen. Describe any fissures, scars, or adhesions within the vagina. Describe the condition of the hymenal ring and measure the diameter of the hymenal opening and the vaginal opening.

For males, careful inspection of the penis, scrotum, and rectum should be performed. Describe any lesions, discharge, edema, blood, erythema, or lacerations and note the rectal tone.

In summary, physical findings suggestive of sexual abuse include:

1. Genital or rectal trauma (signs may include bruises and bleeding of the genitals or perianal area, erythema indicating increased vascularity behind the posterior forchette, small healed transections of the hymen, thickening and/or hyperpigmentation of the labial skin, or any abrasions, lacerations, or edema);
2. Foreign bodies in the vagina, rectum, urethra, or penis;
3. Dilation of the vaginal opening, urethra, or rectum;
4. Evidence of semen or acid phosphatase on the child's body or in the urine of females;
5. Trauma to the breast, buttocks, thighs, or lower abdomen;
6. Evidence of sexually transmitted diseases, including gonorrhea, syphilis, genital herpes, trichomonas, chlamydia (beyond 6 months of age), lymphogranuloma venerum;
7. Vaginitis - nonspecific or candidiasis;
8. Recurrent urinary tract infections;
9. Pregnancy.

CULTURES

All children with any history of possible sexual abuse should be tested for gonorrhea and chlamydia at three sites. For gonorrhea, a pharyngeal swab and a vigorously obtained rectal swab should be sent. In girls, an endocervical swab will most likely yield positive cultures with recent contact. A urethral swab is more reliable if it has been several days since exposure. In boys, a urethral swab should be sent.

For chlamydia, cultures of the pharynx, rectum, and endocervix or vagina in girls, and the urethra in boys, should be obtained with calcium alginate swabs (N-P Swabs). They should be sent on ice in chlamydia transport media to a bacteriology laboratory. Rapid diagnostic tests such as the chlamydiazyme test are less preferable.

All females with vaginal signs or symptoms should be cultured for the other sexually transmitted or associated diseases:

Gardnerella vaginalis: Non-specific vaginitis appears to be a synergistic infection involving Gardnerella vaginalis and various anaerobic bacteria in girls. A vaginal swab should be sent for a culture "R/O Gardnerella vaginalis.
Microscopic examination is performed by injecting 2mm of sterile saline into the vagina which is then aspirated. One drop of the obtained fluid is then placed on the slide with a drop of 10% KOH. This yields the presence of a fishy odor. Another drop of the wash should be examined under the microscope for the presence of clue cells (epithelial cells heavily studded with bacteria).

Trichomonas: The vaginal wash obtained above can be examined for the presence of live organisms under the microscope. A discharge obtained with a swab can be mixed externally with saline and examined in the same manner.

Candida: A vaginal swab can be sent. The vaginal discharge may also be mixed with KOH and the presence of mycelia can be observed microscopically.

LABORATORY EXAMINATION

Blood Studies:

1. For all children with a possible history of sexual abuse, an RPR should be sent and repeated in three months if no prophylactic treatment was prescribed (the incubation period for syphilis is 10-90 days).
2. For all physically and/or sexually abused children with significant bruising, a CBC with differential and platelets and a PT, PTT, and bleeding time should be sent.
3. A B-subunit HCG assay should be sent on all post- pubertal females with a history of possible sexual abuse, and a negative urine pregnancy test.

Urine:

1. A U/A and urine culture should be sent on all children with abdominal trauma or a history of possible sexual abuse.
2. A urine pregnancy test should be sent on all post- pubertal females with a history of possible sexual abuse.

SPECIAL SPECIMEN COLLECTION FOR ACUTE SEXUAL ASSAULT (RAPE)

If the child is the victim of an acute sexual assault (<72 hours after the incident), then history, examination, and collection of evidence should be performed in a hospital emergency room. There are legal requirements and options regarding reporting and subsequent legal proceedings. If at some future date the patient's family wishes to prosecute, it is important that collection of materials to be used as evidence be methodical. Full instructions are available in a Rape Evidence Collection Kit. Written consent is required to release evidence methods.

The specimens and evidenciary materials materials listed below should be collected and labeled with the patient's name, date, time, source, physician, hospital, and patient's hospital number. A chain of evidence form must be signed by hospital personnel receiving the materials.

All specimens or evidenciary materials preceeded by an asterisk (*) below are for use by the law enforcement agency if consented to by the victim. A chain of evidence must be signed by the law enforcement officer receiving the materials (form available in the Rape Kit).

A. *Clothing: Appropriate articles of clothing (underwear, stained or torn garments, etc.) should be placed in the paper bag provided.

B. *Foreign Materials:

1. Any foreign material noted (mud, nail scrapings, etc.) should be collected and placed in the container provided in a Rape Evidence Collection Kit.

2. The pubic hair (of a pubescent victim) should be combed for foreign materials and a sample of the victim's pubic hair should be collected and placed in the appropriate containers in a Rape Kit.

C. Vaginal Aspirate: If indicated (e.g. ejaculation suspected). The vagina may be swabbed if no aspirate is present (oral and rectal samples may be indicated).

1. Wet smear for motile sperm. A small amount of sample is placed on slide, one drop of saline is then added, and the sample is stirred and covered with a cover slip. A pathologist should read this slide. If unavailable, another physician may do so.

2. Vaginal aspirate for acid phosphatase analysis. The remainder of aspirate is then placed in a sterile test tube and sent to the lab for quantitative analysis of acid phosphatase. If the test cannot be done immediately, the sample should be kept frozen.

3. *Air Dried Slides: A swabbed sample of vaginal fluid is taken from the posterior fornix, a small amount is placed on each of the two slides (provided in the Rape Kit) the slides are allowed to air dry (no fixative), and are then placed in the designated envelope. The swab is placed in the sterile tube and returned to the same envelope.

4. Vaginal (rectal and/or oral, if indicated) wash: The wash is performed with 5 cc of saline and the sample aspirated and placed in a sterile tested tube to be tested for acid phosphatase. This specimen must be labeled as a vaginal (oral, rectal) wash including the amount of saline used. If the test cannot be done immediately, the sample should be frozen.

D. Vaginal culture for N. gonorrhea: Rectal and oral cultures may be indicated.

E. *Saliva: A 2" x 2" gauze is placed in the patient's mouth and then in the designated envelope (Rape Kit) to study acid phosphatase.

F. RPR: A blood sample for serology testing (2cc red-topped tube).

G. Blood Typing: A blood sample for blood type (10cc red-topped tube).

H. UCG: A urine sample for pregnancy testing in a pubescent female.

I. *Fingernail Scrapings and/or Cuttings: Necessary collection tools are found in large Rape Kit.

J. Cervical Culture for Chlamydia and other routine cultures as indicated.

If evidentiary materials have been collected, but the victim has not consented to their release, they are to be kept for six months in the event that the victim decides to prosecute.

TREATMENT

1. Specific injuries should be treated as necessary.

2. Pregnancy prophylaxis may be prescribed (with informed consent) for post pubertal females within 72 hours of probable coitus.

   Ovral (0.5mg norgestrol + 0.01mg ethinyl estrodiol)
   2 tablets po STAT
   2 tablets po 12 hours later (99% effective)

3. Sexually transmitted diseases should be treated according to current recommendations (see 1985 STD Treatment Guidelines).

MEDICAL FOLLOW-UP

1. Children with serious injuries or at risk of serious harm should be admitted to a hospital. Otherwise, children should be sent to a setting where they are at no risk of further abuse.

2. Children who are treated for any reason should be seen after cessation of the treatment period in follow-up.

3. All children with positive cultures should be recultured after treatment.

4. All children with a history of possible sexual abuse should be followed in three months for a repeat RPR.

CHECKLIST FOR SEXUAL ABUSE

___ History

___ Physical Examination

  ___ Signs of Physical abuse/neglect
  ___ Genital/rectal Exam

Female
__ labia
__ hymen (measure opening)
__ vagina
__ cervix
__ fundus
__ adnexae
__ rectum

Male
__ penis
__ scrotum
__ rectum

Cultures

___ Vagina/Cervix for GC

___ Vagina/Cervic for Chlam.

___ Pharynx for GC

___ Pharnyx for Chlam.

___ Rectal for GC

___ Rectal for Chlam.

___ Urethral for GC (Males)

___ Urethral for Chlam. (Males)

If symptomatic female:

___ Wet smear for trichomonas, gardnerella

___ KOH smear for candida

___ Vaginal culture for gardnerella

___ Vaginal Culture for candida

Laboratory Exam:

Urine:

__ U/A

__ Urine Culture

__ HCG if Post-pubertal

Blood:

__ RPR

__ B Subunit HCG if Urine is negative

__ Hospital Social Services notified

__ 51-A

  __ Verbal Report

  __ Written Report

__ 51-C

__ Treatment

____

____

__ Disposition

____

____

__ Follow-up arranged

____

____

____

__ Primary Physician Notified

CHECKLIST FOR ACUTE SEXUAL ASSAULT

- __ Contact Sexual Assault Team (if applicable)

- __ History
  - __ Date, time, circumstances of assault
  - __ Menarche, LMP
  - __ Birth Control
  - __ Medications

- __ Physical Examination
  - __ Appearance, emotional state, behavior
  - __ Vital signs
  - __ Tanner stage
  - __ Evidence of trauma

  - __ Pelvic examination for females
    - __ Vulva
    - __ Hymen
    - __ Introitus
    - __ Vagina
    - __ Cervix
    - __ Fundus
    - __ Adnexae
    - __ Rectum

  - __ Examination for Males
    - __ Penis
    - __ Scrotum
    - __ Rectum

- __ Wood's Lamp for Semen

Cultures:
- __ Pharyngeal culture for GC
- __ Pharyngeal culture for Chlam.
- __ Rectal culture for GC
- __ Rectal culture for Chlam.
- __ Endocervical/Urethral culture for GC
- __ Endocervical/Urethral culture-Chlamydia

Specimens for Sperm/Acid Phosphatase and Microscopic Examination
- __ Wet smear vagina
- __ Wet smear pharynx
- __ Wet smear rectum
- __ Aspirate/wash vagina
- __ Aspirate/wash pharynx
- __ Aspirate/wash rectum

- __ Evidence Collected

  - __ Clothing ________
  - __ Pubic Hair Combings & Clippings
  - __ Saliva Sample
  - __ Foreign Debris (where)
    ____
    ____

  - __ Dried Secretions (where)
    ____
    ____

- __ Two air dried slides and swab samples

  - __ Vagina
  - __ Rectum
  - __ Pharynx

Laboratory Tests:
- Urine:
  - __ HCG
  - __ U/A
  - __ Urine Culture

- Blood:
  - __ RPR
  - __ Blood Type
  - __ B-Subunit HCG if urine negative

- __ Hospital Social Services notified

- __ 51-A
  - __ Verbal Report
  - __ Written Report

- __ 51-C

- __ Treatment

  ____

- __ Disposition & Follow-up

  ____

- __ Primary Physician Notified

- __ Police Notified
  Date ________
  Time ________

Resource Materials

INTRODUCTION

The following listing is not intended to be comprehensive. The numbers of audiovisual materials, anatomically correct drawings and dolls for use at many age levels, teaching aids, and books for children and families, to say nothing of the professional literature in the field, are growing and improving rapidly. To keep current with such growth, all professionals need to consult their own professional resources in this area. We have, however, listed some sources of audiovisuals and anatomically correct dolls in order to provide non-specialists with an introduction to the variety of presentations currently available. Furthermore, we begin this section with an introduction to national and regional centers which can provide current information on many topics related to child sexual abuse.

1. National Resource Centers

A. The National Center on Child Abuse and Neglect. This division of the United States Department of Health and Human Services has a large clearinghouse which is, if desired, also accessible through electronic database vendors in addition to printed materials. National Center - 202/245-2856. Clearinghouse - 301/251-5157.

B. The National Institute of Mental Health provides a broad range of research information: Division of Communications and Education, Science Communications Branch, Public Inquiries Section, Room 15C-17, 5600 Fishers Lane, Rockville, Maryland 20857. 301/443-4513.

C. American Bar Association/ National Legal Resource Center for Child Advocacy and Protection, 1153 East 60th Street, Chicago, Illinois 60637. 312/947-4000.

2. Regional Resource Centers

A. Berkshire Area Health Education Center (AHEC)
Child Sexual Abuse Projects
Berkshire Medical Center
725 North Street
Pittsfield, MA 01201
Joanna Ezinga
413/499-4161 ext. 2416

The Berkshire AHEC coordinates two programs on child sexual abuse, the Child Sexual Abuse Prevention Project which provides education and information, and the Coordination of Services and Treatment Project, which facilitates county-wide coordination in sexual assault cases. The Center also has many professional resources, books, cassettes, journals, teaching materials, parents' guides and booklets, and children's books, coloring books, and games. Although these materials are available for loan only in Berkshire County, AHEC staff are widely conversant with resources and will be helpful in locating materials.

B. Family Information Services
4 Longfellow Road
Cambridge, MA 02138
617/876-8895

Many of the resources listed below are available (rental) from this agency. Contact them for most recent listings.

C. Judge Baker Guidance Center
The New England Resource Center for Protective Services
295 Longwood Avenue
Boston, MA 02115
617/232-8390

A number of books and articles are distributed through this center including a comprehensive listing of resources on child sexual abuse.

3. Anatomically Correct Dolls and Anatomical Drawings

Anatomical Drawings: Thirty-two line drawings of front and back views of white and black, male and female, at four age levels (pre-school, grammar school, adolescent, and adult). Accompanying text. A Nicholas Groth, PhD, text; Thomas M. Stevenson, illustrations.
Forensic Mental Health Associates, Inc., 3 Ireland Road, Newton Centre, MA 02159.

Doll Kit: Individual fingers, open mouths, anal openings, toes, ears. Adult females have a vagina, pubic hair, and breasts. Adult males have a penis, scrotum, and pubic and underarm hair. Dolls come clothed and are washable. Adults, 21", children, 17". Also an anatomically correct old man, old woman, and a dog with movable parts. A set consists of any four. Black and white available.
Maple Hill Doll,Janon Inc., 317 East Front Street, Grand Ledge, MI 48837

Doll Kit: Includes one male adult, one female adult, one female child, one male child, a cassette instruction tape entitled *Interviewing the Young Sex Crime Victim with the Aid of Dolls.* Clothes for each doll include top, pants, and undershorts for male dolls and dress and underpants for female dolls. Swimsuits, nightgowns, and pajamas also available.
Migima Designs, P.O. Box 70064, Eugene, Oregon 97401 503/726-5442

Doll Kit: Benign expressions. Each set has a male adult, female adult, male child, and female child. All dolls have fingers and thumbs, mouths, nipples, belly buttons, and anal openings. Female dolls have vaginal openings, and the adult female has breasts and pubic hair. The male dolls have a penis and testicles, and the adult male has pubic hair. Available in white or brown fabric. Clothing has velcro fastenings.
OPR Associates, P.O. Box 1304, Manchester, CT 06040 203/528-1295.

Article: Dawson, Ross. Use of Sexually Correct Dolls in Assessing Child Sexual Abuse. *The Journal* (Ontario Association of Children's Aid Societies) Volume 28, No. 2, February, 1984.

4. Audio-Visual Materials

Better Safe than Sorry III. 16mm film. About child sexual abuse for teenager, for example, date rape, incest, and molestation.
Film Fair Communications, 10900 Ventura Blvd., Studio City, CA 91604.

Child Sexual Abuse: A Solution. Filmstrip and cassette set. A personal safety program on sexual abuse for parents, children, and teachers, K-6, with real experience of children and some animation of characters.
Family Information Services, 4 Longfellow Road, Cambridge, MA 02138.

Child Sexual Abuse: The Family. 16mm, color. 30 minutes. Highlights the importance of careful and humane initial management of victims and families. Stresses the key roles parents, police, and medical personnel play in helping the child overcome trauma. The correct procedure for conducting a physical examination of the victim is explained. For professionals and child advocacy groups.
Regional Resource Centers on Child Abuse and Neglect.

Child Sexual Abuse: Trauma and Treatment. Synchronized slide-tape cassette and 16mm film, color. 24 minutes. Developed for use with community groups and as introductory material for professional workshops and training sessions. Highlights the multidisciplinary approach to crisis intervention in a pediatric hospital.
Regional Resource Centers on Child Abuse and Neglect.

Don't Hurt Me Daddy. Synchronized slide/tape cassettes and videotapes. Variable length. For use with community groups and public awareness campaigns. Focuses on child abuse and neglect.
ACCESS, Milwaukee County Department of Social Services.

Double Jeopardy. 16mm, color. 40 minutes. Designed to sensitize professionals to the trauma which the child victim often experiences during the lengthy judicial proceedings in cases of child sexual abuse. Case histories demonstrate the benefits of an interdisciplinary approach to management of the child and family. For professionals.
MTI Teleprograms, Inc. 420 Academy Drive, Northbrook, Il 60852.

Feeling Yes, Feeling No: Three Films for Children and One Adult Film. 16mm and videocassette, color. Film 1, 14 minutes; Film 2, 14 minutes; Film 3, 16 minutes; Adult film, 27.5 minutes. For elementary school students. Produced by the Film Board of Canada, 1984. Adult film dicusses the nature and scope of child sexual abuse and introduces the series for children. The three films for children build on one another. The first introduces basic skills of self-protection. Film 2 explains sexual assault, how to recognize a dangerous situation and protection skills. The third film discusses sexual assault by a trusted adult. Support materials accompany each film.
Perennial Education, 930 Pitner Ave., Evanston, IL 60202

Fragile: Handle with Care. 16mm. 26 minutes. Three actual child abuse cases which are re-enacted.
Independent Order of Foresters, 100 Border Ave., Solana Beach, CA 92075.

If It Happens To You. Videocassette, filmstrip/cassette, color. 26 minutes. Four children's stories about their experiences with a potential abuser, and how they avoided the abuse by being assertive. For elementary students.
Sunburst Communications, 39 Washington Ave., Pleasantville, NY 10570.

Incest: The Broken Silence. Three quarter inch videotape, color. 30 minutes. Emmy award winning documentary which explores some methods available to help decrease the trauma to victims. Examines alternative means of using community resources to provide needed services. For use with community groups and in public affairs programming.
KPBS Television, San Diego.

Incest: The Victim Nobody Believes. 16mm color. 21 minutes. Three women's discussion of their childhood as victims of incest.
MTI Teleprograms, Inc. 420 Academy Drive, Northbrook, IL 60862.

The Last Taboo. 16mm, color. 30 minutes. Award winning film presenting the stories of six childhood sexual abuse victims. The strong emotional impact stems from live filming of victims reliving their experiences during a therapeutic workshop. For clinicians and other professionals.
MTI Teleprograms, Inc. 420 Academy Drive, Northbrook, Il 60862.

Personal Safety and Decision Making. Videocassette, color. 14 minutes. Five situations are presented to promote discussion about assertiveness techniques. Teacher's guide included. For grades 6-9.
Committee for Children, 172 - 20th Ave., Seattle, WA 98122

Rethinking Rape. 16mm and videocassette, color. 26 minutes. Interviews a variety of individuals about the complex issues of acquaintance rape. A former model, a social psychologist, a rape crisis center director, a journalist, and a male college student speak about the problem, causes, and possible personal and societal solutions.
Jeanne M. LePage, Partington Ridge, Big Sur, CA 93920.

Sexual Abuse of Children: America's Secret Shame. 16mm, color. 30 minutes. Intended for community groups and professionals new to the field. Emphasizes increased awareness and understanding of the problem.
AIMS Instructional Media, Inc. 626 Justin Ave., Glendale, CA 91201

The Sexually Abused Child: Identification/Interview. 16mm, color. 10 minutes. Demonstrates the techniques an interviewer can use to elicit information from a child without further traumatization. A teacher carefully elicits a history of sexual abuse from one of her students. For professionals.
MTI Teleprograms, Inc. 420 Academy Drive, Northbrook, Il 60862.

Some Scars Do Not Show. 16mm, VHS. 10 minutes.
Sometimes Its Okay to Tattle. 16mm, VHS. 10 minutes.
Some Secrets Should Be Told. 16mm, VHS. 10 minutes.
K-6, about child sexual abuse, with puppets.
Family Information Services.

Who Do You Tell? 16mm, color, and U-matic video cassette. 11 minutes. Animation interspersed with live footage of children talking honestly about who they would tell if confronted by a serious or frightening problem. Problems discussed include fires in the home, discovering that a friend has been severely beaten by her parents, and who to tell if an adult gets close to you in a way that makes you feel uncomfortable. For children, seven to twelve.
MTI Teleprograms, Inc.

Yes You Can Say No. Videocassette, color. 19 minutes. Designed to be used as part of a personal safety curriculum. Models assertiveness skills in specific situations - with peers and adults - through the story of David, who is sexually abused by his uncle.
Committee for Children, 172 - 20th Ave., Seattle, WA 98122.

SUGGESTIONS FOR ADDITIONS AND CORRECTIONS TO THE REFERENCE MANUAL

WORCESTER AREA CHILD SEXUAL ABUSE TASK FORCE
c/o MSPCC, 268 Lincoln Steet, Worcester, MA 01605

Date ____________________

Name of Agency/Organization ____

____
(Street Address)
____________________, MA ________ 617/____________
(City or Town) (Zip) (Phone)

Person(s) Responding to this Request:

Name ___________________________ Title _____________________________

___________________________ _____________________________

Please give comments and suggestions below:

REQUEST FOR INFORMATION

WORCESTER AREA CHILD SEXUAL ABUSE TASK FORCE
c/o MSPCC, 268 Lincoln Steet, Worcester, MA 01605

Date ____________________

Name of Agency/Organization ____

____
(Street Address)

____________________, MA ________ 617/____________
(City or Town) (Zip) (Phone)

Person(s) Responding to this Request:

Name ____________________________ Title ____________________________

____________________________ ____________________________

This Request for Information is divided into three Sections. Section 1 asks for a comprehensive summary of the services which you provide to various client groups in child sexual abuse cases. Please check all boxes that apply.

Section 2 asks for a verbal description of each type of service which you provide. The responses in this section will serve as (1) a way for you to define what you mean by each of the service types, and (2) a way to make more specific the services which you provide. This information is especially important when there are client restrictions (e.g. teen women and juvenile offenders). It is also helpful to know the scope of services (e.g. prevention/education) or specific type of service (there are some differences which are obvious such as assessment and individual therapy as performed by pediatrician vis a vis a psychologist). Thoughtfulness in your responses to Section 2 will help assure that we mean similar services when we use similar names.

Section 3 asks for a few summary characteristics of service delivery, and the name of a contact for each of the client groups.

If you have printed materials which describe your services for sexually abused children in greater detail, we encourage you to enclose them. Finally, the services which you describe here must be available to residents of Region II, even though the program may not be physically located in Region II.

1. PROFESSIONAL SERVICES DELIVERED TO CHILD SEXUAL ABUSE CLIENTS

Summary of all Services Provided to all Types of Clients

Client Group Delivery	Children 0-5 yrs.	Children 6-12 yrs	Teens 13-18yrs	Non-Offending Mothers	Offenders	Adult Survivors of sexual abuse	Other* specify
Crisis Intervention							
Assessment							
Diagnostic Testing							
Advocacy							
P.A. Support/Self-Help Grps.							
Prevention /Education							
Law Enforcement							
Individual Therapy							
Group Therapy							

Do you run couples groups? Yes ______ No ______

Do you run family groups? Yes ______ No ______

Please describe any other services which you provide and give details on the client group(s). Also describe any specialized teams, both within your organization and in concert with other organizations, which are directed specifically at child sexual abuse interventions. Please make attachments to this Request for Information if necessary.

* Other client groups include non-offending fathers, siblings, other family members or caretakers, non-family members, etc.

2. SERVICE DELIVERY DESCRIPTIONS

Detailed Definitions of Types of Service

CRISIS INTERVENTION:

ASSESSMENT:

DIAGNOSTIC TESTING:

ADVOCACY:

PROFESSIONALLY ASSISTED SUPPORT OR SELF HELP GROUPS:

PREVENTION/EDUCATION:

LAW ENFORCEMENT:

INDIVIDUAL THERAPY:

GROUP THERAPY:

COUPLES AND FAMILY THERAPY:

OTHER:

3. SERVICE DELIVERY CHARACTERISTICS FOR CHILD SEXUAL ABUSE CLIENTS. Please fill in the matrix below as completely as possible for all client groups whic your organization serves.

Client Group Delivery	Children 0-5 yrs.	Children 6-12 yrs	Teens 13-18yrs	Non-Offending Mothers	Offenders	Adult Survivors of sexual abuse	Other(sp cify:
Fees (if more than 1 fee structure please list or append all)							
Other Reimbursement*							
BC/BS							
Medicaid							
Other							
Annual Number Served							
Average Waiting List Time							
Contact: Name	________	________	________	________	________	________	______
Title	________	________	________	________	________	________	______
Phone	________	________	________	________	________	________	______

* Please explain in the space below (1) any limitations which are placed on the number of client contacts (and give the number allowable), and (2) your procedure for handling clients when third party payment or other funding expires.

(1) Existing Limitations Yes ____ No ____ Number: Individual ____
Family ____

(2) Procedure(s)

REQUEST FOR TRAINING

WORCESTER AREA CHILD SEXUAL ABUSE TASK FORCE
c/o MSPCC, 268 Lincoln Steet, Worcester, MA 01605

Date ____________________

Name of Agency/Organization ____

____
(Street Address)

_____________________, MA _______ 617/_______________
(City or Town) (Zip) (Phone)

Person(s) Responding to this Request:

Name __________________________ Title ____________________________

__________________________ ____________________________

The contents of this Professional Resource Manual provide a comprehensive outline for more extensive explorations of the topics introduced here. The Worcester Area Child Sexual Abuse Task Force would like to know about training interests of agencies and organizations providing interventions in child sexual abuse. Of special interest is whether short training sessions or longer, more formal training is desired. If you are interested in one or the other type of training, please describe your requirements below.

A. Topic(s) for Consideration during Training:

B. Site(s) of Training:

C. No. of People to receive training at each site:

D. Profession(s) or Occupation(s) of Trainees:

E. Requested Date(s):

F. Length of Program (hours):

G. Suggestions for Structure of Program:

H. Additional Comments: